Jan Arogya Andolana – Bangalore Urban

Report on Health of the urban poor held on Peoples Health Day – 7th April 2003

At Ashirwad Bangalore, facilitated by Community Health Cell and KKNSS

Report by : S.J.Chander

Background

World Health Organization (WHO) having recognized that the health services expected by the people was not being provided, in 1997 during the World Health Assembly called for a revolutionary approach In Health Care that would enable the citizens attain a level of health that will permit them to lead a socially and economically productive life. In 1978 in the conference held in Alma Ata, Russia, Health For All by 2000 AD was declared. Primary Health Care approach evolved based on the experiences of countries like Sri Lanka and India was suggested as the best way to attain the goal. Services based on PHC approach were developed over the years for the rural poor but to far the urban poor the services available were family welfare and family planning.

He said the PHC approach though initially experienced some gains, gradually moved from comprehensive health care to more a selective primary health care approach. Pulse polio programme can be given as an example. National Health Policy 2002 draft is out and it is evident in it the shift. Process of globalization and influences of various lobbies are some of the factors that have had negative effect on people health. Of late the trend is moving more towards privatization.

This year is the silver jubilee of the Alma Ata declaration, it appears that WHO and the governments have forgotten the goal Health For All (HFA) by 2000 AD. Jan Swasthya Abhiyan (JSA) in India, known as People's Health movement internationally believes that it is the comprehensive health care that is going to help people attain the level that was envisaged by WHO during the declaration. It is time that both the government and the people's organization work together to achieve Health for All now!

Dr. Mala Ramachandran, Director, Urban Health Training and Research Center, Bangalore who was invited to share on the health services available for the urban poor said, approximately there are 15 lakhs people live in the slums of Bangalore. Population growth is the cause of the state of affairs in the slums. Usage of MCH services and Immunization coverage is low. Problems like cancer, diabetes, hypertension is prevalent. HIV AIDS and Tuberculosis are the other problems of concern to the urban poor. Safe drinking water and sanitation continue to be inadequate. During the response to Dr. Mala's presentation, the participants said, despite the efforts to control corruption, it is still rampant. There was concern among the participant regarding the removal of Link Workers who were working at slum level.

Followed by Dr. Mala's presentation, Mrs. Ruth Manoramma of Women's Voice shared urban poor do not have policy to address their needs. She said national policy of urban poor is being developed. The present family welfare programmes exclude men from the service coverage. Regarding sanitation needs, she said 70% of the Indian population still

does not have toilets. Women are the ones who are affected more due to lack of toilet facilities. From the 9th five-year plan it was observed the budget for health being decreased and budget for social welfare continued to face cut. The critiques have said the following: Public sector is moving towards privatization, public sector budget faced cut, commodification of health care, population gets major focus and distortion of priorities. Regarding her suggestions to change the scenario, she said the following:

1. We should demand for comprehensive primary health care
2. Introduction of barefoot doctors cadre and youth for prevention HIV/AIDS ?? other diseases also
3. Recognize urban health as an important component in Health Care services
4. Obtain information regarding health care services and disseminate widely among people
5. People should demand for transparency and accountability with the govt. services.
6. There is need to understand socio cultural and economic dimension of the causes of the illnesses.

Followed by Mrs. Ruth's presentation Ms. Preetham of Janagraha shared about their work in developing indicators for the health services. She said at present Jangraha is involved in the following three campaigns: a. ward work campaign, b. Proof campaign, and 3. Ankoor, which focuses on the services of SJSRY. They approach they have adopted is budget analysis, in which they analyze the budget allocated, actually spent and the quality of service. As an example she gave the education budget of the ~~MBP~~ BMP when worked out the equation, the total cost per child per year works out to Rs. 29,000. She said the output for such a high investment is unacceptable. She said without information based on evidence objective discussion is not possible with the service providers and performance indicators help us demand accountability. At present she said they are experimenting with the approach: collect information, analyze, and organize management dialogue for improvement with education and heath care sectors of BMP.

Mr. Madhusudhan of KKNSS concluded the meeting with vote of thanks. It was decided at the end of the meeting to form a forum consisting of voluntary organization working with the urban poor for identifying and addressing the issues of concerns to urban poor under Janaarogya Andolana.

attach indicators list; needs to be discussed (the indicators)

PERFORMANCE INDICATORS FOR HEALTH

INPUT	OUTPUT	OUTCOME	EFFICIENCY	PRODUCTIVITY	EXPLANATORY
• Minimum Infrastructure Standard General Ward Labor Ward Operation Theatre (OT) Minor Operation Theatre Toilets Condition of toilet Bathrooms: -- Availability of hot water -- Availability of sewage system. Laboratory Waiting Area Patient Attendant Space Outpatient Area Availability of drinking water Linen Service Generator set Store Room Ambulance Service Quarters for Doctors and Drivers Telephone Service Privacy of examination area Fumigation • Minimum Equipment Standard. Availability of required Equipment in all rooms. • Drugs Availability of minimum essential drugs. Availability of emergency drugs.	• Number of deliveries Normal Caesarean and Assisted • Number of family welfare procedures. • Number of high risk pregnancies detected during labor / antenatal care • Number of immunizations against measles. • Number of admissions. • Number of admission slips. • Number of patients registered for postnatal care. • Number of patients registered for antenatal care. • Number of Medically Terminated Pregnancies (MTP).	• Number of maternal deaths. • Number of neo natal deaths. • Number of stillbirths. • Number of infant deaths. • Number of perinatal deaths. • Number of measles cases. • Number of deaths due to measles • Number of admission to number of admission slips. • Complaint redressal system. • Patient feedback forms. • Percentage of patients coming in for 3 postnatal check ups. • Number of patients registered for antenatal care prior to 12 weeks. • Number of days with stock outs of essential drugs.	• Downtime of key equipment. Autoclave. Laproscope. Refrigerator. Generator. Ambulance BP Apparatus Instrument Sterilisers Weighing Machine – Adult and Infant Incubators Boyle's Apparatus Pulse Oxinator Hysteroscopes • Time taken to fill up vacancies to sanctioned strength. • Nurse patient ratio. • Doctor patient ratio. • Full time employees per occupied bed. • Waiting time for patient. • Cost of drugs per patient (inpatient / outpatient). • Cost per inpatient day. • Cost per outpatient day.		• Staffing patterns. • Number of patients below the poverty line. • Inventory / Store management maintenance mechanism.

• Furniture. • Stationery for correspondences. • Staff (Sanctions, Vacancies and Absentees) Doctors Staff Nurses Auxiliary Nurse Midwives (ANM) Lab Technicians Peons Ayahs Sweepers Drivers Dhobhi's (Contracted) • Capacity Building Type of training programme. Periodicity of training. Number of people trained. • Financial Salaries budget Maintenance budget - Equipment Maintenance budget –Building Drugs budget. Equipment budget. Training Budget. Fuel and vehicle maintenance budget User fees Laundry budget Contractual Services budget Miscellaneous expenditure budget	• Number of complaints. • Number of outpatients per day. • Number of referrals. • Number of prescription slips issued • Number of visits by the health officer/ supervisor • Use of equipments	• Display board of available drugs. • Amount of user fees collected. • Bed occupancy rate. • Number of deaths due to sterlisation	• Utilisation of user fees. • Percentage of high risk cases among deliveries • Number of complaints received to number of complaints redressed		

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11th April 2003

Dear friends

Greetings from Community Health Cell !

Subject: **One day workshop on tuberculosis for non –health voluntary organizations working with the urban poor, jointly organized by CHC, BMP, NTP and KSTA.**

Tuberculosis is one of the major communicable diseases that kills more than 5 lakhs people in India. TB affects people in the reproductive age group, particularly the poor. TB was a dreaded disease 50 years ago without any drugs for cure, killing many people. Thanks to the medical research, which helped in inventing drugs for curing. This disease which was called the white plague.

TB is curable if the person regularly takes the treatment, which is for a longer duration, from 6-9 months. In India the government is making the treatment available free of cost through the RNTCP (Revised National Tuberculosis Control Programme) using DOTS (Directly Observed Treatment Short Course) approach in a few districts. Bangalore urban district is one such district.

Though the treatment is available free of cost, there are problems from the perspectives of both the treatment provider and the user. This workshop aims to evolve a collaborative effort by government and Voluntary organizations in overcoming the problems thereby assuring cure for the patient. At the end of the workshops the participant will be able to:

1. Understand the nature, magnitude and action taken by government for combating TB
2. Identify areas of concerns.
3. Begin to evolve an action plan in collaboration with BMP to make TB care and control in Bangalore urban effective especially for poor and vulnerable sectors of society.

This workshop will be held at: **Community Health Cell (address given in the letter pad)**
On: 3rd May 2003 from 9 am – 5.00 pm

Kindly confirm your participation at the earliest. Looking forward to meeting you to work together with you.

With Best Wishes!

Yours sincerely

S.J.Chander
For Community Health Cell

JANAAROGYA ANDOLANA - KARNATAKA

Action Plan for Intervention for Bangalore City for the year 2003-04

- (For Discussion Only)

Goal

To enable a better healthy environment and access to health services for the urban poor in bangalore city

Objectives

- To build capacity of the Organisations/CBOs to equip them to address the health issues in the BMP area
- To Facilitate better accessibility of urban poor's Access to Health services provided by the BMP
- To mobilize ~~the~~ all stakeholders concerning health to directly address the burning health issues in various locations of Bangalore city

Output

- Training programmes regarding health on Infant Health, Nutrition, Adolescents , reproductive health, communicable diseases(AIDS, Cholera, Typhoid, Malaria), non-communicable diseases(Diabetes, Cancer, Hypertension), occupational health (Construction, Municipal Workers, Domestic Workers) and Substance Abuse(Alochol, Tobacco)
- Health Camps or disease detection camps at various locations of bangalore city
- Evolving mechanism for monthly interaction between the users and providers of BMP
- Direct Action on Explosive health hazards at various locations of the city which affects the slum dwellers.

St. Johns
St. Marthas

Indicator

- Training programme on 2 health topics every month
- 2 detection camps for detecting the scale of cancer and diabetes among slum dwellers
- Health Adalat - Complaints, grievances of urban poor presented before the doctors & staff of the health centres. Conducted at each health centres level for every month
- Improving environment at EWS quarters, slums adjancent to Storm drains. Slaughter houses, and building health infrastructure

Activities

SL No.	Activity	Process Indicator	Product Indicator
1	Capacity building	50 Health workers, field workers and CBOs will be trained. Resource material will be distributed and evolving action plan	Infant Health Nutrition Immunisation Communicable diseases Non-Communicable disease Adolescent health Reproductive health Occupational Health Substance Abuse
2	Health/Disease Detection Camps	3 Health detection camps for organising detection of high concentration of diseases such as tuberculosis, cancer and diabetes	Document on Findings of the detection camp Strategy document on curative and preventive measures to contain the diseases
3	Monthly Interaction between slum dwellers and service providers of BMP's Health Infrastructure	12 monthly interaction at 55 IPP centres per month. The doctors, staff, CBOs. slum dwellers interact to improve the services of health infrastructure	Health Adalat - a mechanism to for exchanges between users and providers of BMP's health system.

4	Direct Action to pre-empt an explosive unhealthy situation	Organising inspections from the government agencies. Media splash Enabling systems within government to prevent such situations	Building up an health environment in slums adjancent to Storm drains Improving the environment in Vinobanagar, Shambupalya slum etc., Improving the environment within the slaughter houses on tannery road and protection of slum dwellers who work there.

Status of Health in the Slums of Bangalore City

By
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Introduction

Health is a complete state of Physical, mental and social well being and not merely the absence of disease of infirmity[1]. Access to health care was one of the indicator of measuring reduction in poverty of underprivileged masses in the rural and urban poor areas of the country. One of the important components of health care system of consists of : primary, secondary and tertiary care institutions, manned by medical and para-medical personnel. The Primary Health Care Infrastructure provides the first level of contact between the population and health care providers. Realising its importance in the delivery of health care services, the state and central government has started primary health centres[2].

About 30% of the India's population live in the urban areas. The health care system is much better compared to the rural areas. However , the urban migration has resulted in growth of slums. The slum population face greater health hazards due to over crowding, lack of sanitation, no proper access to drinking water and environmental pollution. Realising that the health infrastructure is insufficient due to the growth of urban population, the local government, state government and central government has built up urban health care facilities. But, there has no effort to provide well planned and organised, primary secondary teritary care services. Dispensaries, Primary Health Centres, Government Hospitals and Referral hospitals are the four tiers of the health care system in the urban areas in the country.

Urban Poor in Bangalore city

In Bangalore city, there are about 472 slums[3] in the Bangalore city. Of which 202 are declared under section 3F of the Karnataka Slum Areas Act 1973. The slum population in the declared slums will provided with basic amenities only the slum is declared. Therefore the number of undeclared slums in bangalore city is 270 on the lands owned by government agencies, private owners, railways ,defence lands etc., A more realistic figure came from the National Sample

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[1] . Definition by World Health Organisation
[2] .Tenth Five Year Plan Document on Health, Planning Commission of India, 2003
[3] . Commissioner , Karnataka Slum Clearance Board, March 2003

Survey, 49th Round, in 1993. Here, the slum population was estimated at 32.2 lakhs, making it around 23 per cent of the total urban population in the State. This study estimated the population of Bangalore's slums at 10 lakhs[4].

I. Health Status of Urban poor in Bangalore city

1. Malnutrition

About 70% of the children in the slums of Bangalore city suffer from malnutrition[5]. A significant reason for this is poverty many people cannot afford regular nutritious meals in the slums. In times of economic stress, this becomes frank malnutrition; the body under such condition is unable to resist disease and succumbs to it

Children in the slums suffer undernutrition : 1.Marasmus, which is wasting; frequent cause is underfeeding, diarrhea and infection;2.Kwashiorkor, marked by swelling of the body. Swelling is due to a fall in circulating proteins. Stunting (poor height gain) in the slum is the commonest type of malnutrition in childhood. Some children may be underweight. Both height and weight suffer due to malnutrition.

Anganwadi(ICDS)

Anganwadi is a community health programme for improving nutrition, health and pre-school education of children. At present, it covers the slums and other backward areas in Bangalore city. The target group is children under 6 years.

The target group is divided into two sub-groups, one below 36 months and the other above 36 to 72 months. The younger group stays at home with the mothers. So this programme is ineffective for the younger babies without home visits. The other group - above 3 years - is accessible in the Anganawadi (which is a balwadi and feeding centre). Anganwadis are held in the morning. The primary health centre is expected to undertake immunisation and health checkups in the ICDS programme. The anganwadi worker , who is usually a slum woman with some formal education, conducts teaching activities too. The helper woman does the cooking and feeds the children's. The functioning of the Anganawadis need to be reviewed jointly by the Government and NGOs and its co-ordination with Primary Health Centres. The low rate of immunization (except pulse polio) and malnutrition

[4] Karnataka Housing Revolution, Parvathi Menon in Frontline Magazine, Vol 19, Issue 13 June - July 5,2003

[5] Dr. Mala Ramachandran, Health Officer Bangalore Mahanagara Palika(BMP), World Health Day(April 7, 2003) at Ashirwad, Bangalore

in the age group of younger children in the slums reflects the effectiveness of Anganawadi network in the urban poor areas

2. Environmental Sanitation

Due to scarcity of pure and wholesome water supply, where water is not easily accessible, provision for waste disposal facility and sanitary latrine are in adeuqate. Poor housing conditions, poor personal hygiene, personal habits are causes morbidties in these areas. The inaccessibility to potable water is caused the high rise in the epidemics. The following are the two major causes for the inaccessiblity to water supply system.

(i). Unable to access due to high cost of water connection and service

In order to access the BWSSB water connection to the individual household, a deposit of Rs. 800 is fixed with an water meter attached for monitor the water consumption. The one-time connection charges prove to be an obstacle for many households, both in slums and other areas, in accessing formal connections. BWSSB has decided that certain elements of the connection charge, such as the number of sanitation points charged for(five), can be re-considered and reduced (to two) in view of the small size of houses in slums and low-income areas and the limited number of sanitary fixtures. This element alone can reduce the connection charge by Rs. 360.

The major issue with the slum dwellers is the tariff fixed by the BWSSB. The existing rate of 1 kilolitre of water is Rs. 6 for domestic consumption under consumption slab of 0-15,000 litres and Rs. 8 per litre for the domestic consumption slabs between 15001 to 25,000 slabs. The BWSSB argument for the recent hike in water charges is to cope with the increasing operational costs.

The slum dwellers have been demanding for fixation of subsidised rate for slums and much reduction from Rs. 6 for domestic consumption slab of 0-15,000 litres. On 27-12-2002, About 5000 slum dwellers staged protest rally in Bangalore city under the leadership of KKNSS, Women's Voice and AVAS for subsidised rate for water which was one of their demands. Now, BWSSB has started to experiment for providing subsidised rate for water supply to the slum dwellers.

On March 4 th 2003, BWSSB has started the process of providing subsidized water supply for the slum dwellers in Lingarajapuram Each household will be provided with one water tap, and for a family of five is expected to consume less than 7200 litres of water per month. . The new initiative will cover 1000 families by extending 50 percent concession on connection charges and service charges. The rates for connection charges are Rs. 800 per household and monthly payment of Rs. 115 for consumption of water.

But the majority of the slums in bangalore city are reluctant to accept the BWSSB package due to high cost of the connection and the monthly charge of Rs. 115. The slumdwellers expect the BWSSB to reduce the deposit and monthly charges by half and also a guarantee that the BWSSB's customers in the slums are exempted from future hike in water charges.

(ii). Absence/low capacity of network in the area

The newly formed 32 wards of Bangalore city (from ward no 63 to 100) are out of the BWSSB network. It is estimated that 30% of the slums in the Bangalore city could not avail water supply connection due to absence of BWSSB network in the area. In these slums, the water crisis exist even though water supply is provided through by public taps with mini tank storage systems. Despite this there is acute water crisis in this area.

Chart - Slums of the wards where BWSSB network does not exist and partially exist

Ward No.	Ward Name	Slums	Absence of Infrastructure	Partial Infrastructure exist
1	HMT	12	✓	
12	Nandini Layout	5	✓	
13	Geleyara Balaga Layout	3	✓	
16	Kamalanagara	9	✓	
17	Vrishabhavatinagar	3	✓	
18	Kamakshipalya	3	✓	
19	Basaveshwarnagar	3	✓	
35	Marenahalli	3		✓
37	Amarjyothinagar	2	✓	
38	Mudalapalya	1	✓	
39	Chandralayout	10	✓	
41	Gallianjaneya temple	3		✓
52	Hanumanthanagara	3		✓
53	Srinagara	4		✓
54	Srinivasnagara	13	✓	
55	Padmanabhanagar	8	✓	

56	Ganesh Madira	13		✓
57	JP Nagar	5	✓	
65	BTM Layout	10	✓	
67	Kormanagala	5		✓
68	Ejipura	7	✓	
69	Neelasandra	7	✓	
72	Domlur	10		✓
73	Airport	15	✓	
74	JB Nagar	2	✓	
83	CV Raman Nagara	1	✓	
84	Beniganahalli	8	✓	
85	Sarvagnanagar	13		✓
87	Lingarajapuram	6	✓	
88	Banaswadi	2	✓	
89	Kacharakanahalli	3	✓	
90	Sagayapuram	4		✓
93	DJ Halli	3	✓	
94	Kadugondanahalli	4	✓	
95	KB sandra	4	✓	
96	Hebbal	6	✓	
99	Aramanenagara	4		✓
100	Sanjaynagar	12	✓	
	Total	299	243	56

Source: - BWSSB: ward wise list of its existance of partial or absence of water supply Infrastructure.
BASCIS - list of slums.

Health experts agree that if safe drinking water supply is provided to the slum dwellers, a substantial improved in the health status of the urban poor can be approved. Therefore, BWSSB package of water supply to the slum dwellers should be made available at affordable rates so that the spread of water-borne diseases can be eradicated.

3. Storm drains

Storm Drains network is an the backbone of the sewerage system in the Bangalore urban district. The primary storm drains extend over a length of 184 kms. in the city[6]. They guide water to all the major storm water valleys - Vrushabhavathi, Koramangala , Challaghatta, Hebbal I and Hebbal II. A substantial number of slums are situated on the fringes of storm drains. The conditions of these storm drains is an important factor in the day today lives of the slum dwellers. There are slums where the public water taps which are placed in the storm drains. For instance, in the case of ISRO slum, near the Cambridge layout, the slum dwellers collect drinking water, take bath which is at the silted area in the bottom of the storm water drains. Majority of slums which do not have access to UGD or sanitary lines within the slum, the drainage water flows directly into the storm drain.

(i). Health hazard

In Prakash nagar slum of Ward No. 23, Storm water drains, spanning the ward for about 3.9 kms. are full of filth, garbage and cow dung. The residents of Mariappanapalya slum adjancent Storm water drains suffer from diseases due to unhealthy environment. The storm drains runs near the Harishchandra crematorium, collects waste after funerals are conducted where they stagnate and rot.

In Ward No.26 (Sevashrama Ward) the children of Okalipuram slum, are down with fever due to clogged drain. Garbage adds to the clogged drain, flies and mosquitoes. The air is heavy with stench that breeds disease. Beside, the storm water drain in the area is surrounded by so much of garbage there is no place for drain water to flow.

In Ward No. 32 Dr. Devaiah, a house surgeon at Padma Devaiah Nursing Home in KP Agrahara says unhygienic conditions have brought in several diseases and slum dwellers are complaining of cholera, typhoid, skin diseases or viral infections. There is a urinal which is not maintained and is currently used as garbage bin. Many garbage bins are broken or overflowing.

(ii). Flooding of houses during rains

During rains, the dilapidated storm drains with stench and garbage spell misery to the slum dwellers. In Bangalore, the flow of water is from north to south. The woman of Gandhigram slum[7] are up in arms against the corporation authorities to close the eight feet wide sewage due to its unbearable stink. During rains the sewage mixes up with rain water and rushes into their houses. Out of the 300 houses, 250 of them have no sanitation facility.

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[6] Clogged Network by Aravind Gowda- Deccan Herald, 7 June 2002

[7] . Assessment by Training Research and Documentation Unit, KKNSS

In Ward No 63, adjacent to Chandrappa nagar slum, the huge drainage line looks like a garbage pit. Due to silt formation the sewage is clogged and the whole drain is now filled with garbage. For almost a year neither BCC pourakarmikars nor any one has cleaned this line. If the garbage is not cleared, the rains bring garbage to the streets and even to the houses. Adjacent to Mudalpalya slum, of Ward No 38, The Vrishabhavathi storm water drain is the source of an unholy stench. Most areas are low lying and susceptible to flooding during rains and subsequent overflowing storm water drains. Storm water drain, the collecting point of SWD water from all other wards on the way to the end of the Vrishabhavathi valley at Kengeri. It does not have retaining wall and has never been de-silted. Some rain and SWD overflows onto the residential areas

(iii). Flooding severe in the low lying areas

In the Ward No. 44, Faulty drainage and lack of de-silting in the storm water drains result in flooding of the low lying areas. Slums such as Rayapuram, Kamala Nehrunagar, JJR Nagar, Objlesh slum, Salappa line and Narasimhaiah compound are the most affected. Faulty drainage and lack of de-silting in storm water drains result in flooding of the low lying areas. The Goripalya slum has beef shops as added to the pollution of the storm drains.

From August 2002, the residents of Gandhi Gramam in the city, have been complaining of a stinking eight feet wide open sewage, that often floods their homes during the rains. The resident complain that the smell of the drain in the slum is so bad that during monsoons, when most houses are flooded the smell remains even after the water gets washed away.

One of the problem with storm water drains is blockage due to accumulation of garbage, waste, faulty drainage systems, and abject neglect by BCC in maintenance of the storm drains. Even after ambitious launch of the Swacha Bangalore programme, there is no door to door garbage collection system and waste bins in the slums and many middle class residential areas.

(iv). Blockages of storm drains by military and security establishments

The problem of storm drain has assumed gigantic proportions, due to termination of storm drains near the military and security establishments in Cantonment. The most affected due to storm drains are the slums in the Koramangala and Ejipura ward. The military authorities have terminated the storm drain disconnecting its flow towards Bellandur.

4. Absence of or improper UGD systems in the slums

(i).Internal

The slums of Bangalore city are the most polluted areas due to the absence or non-maintenance of UGD lines by the KSCB or the BMP. The sewerage systems within the slum has added misery to the slum dwellers. Lakshman Rau Nagar slum and Siddapura slum are the worst affected. The following are the factors is the contributor for the sewerage crisis in the slums.

(ii). Faulty design of UGD and sewerage drains

In Sambu Palya Slum of Ward No 48, the serious issue of the toilets is its faulty construction of UGD lines which passes though the narrow lanes of the slums. The frequent overflowing of the septic tanks in the UGD lines has caused severe hardship some families in the slum. The septic tanks are situated in front of houses, the overflowing excreta enter the houses. The faulty design and construction of the community toilet is the crux of the problem. UGD lines from the community toilet move upwards to connect the main UGD line. The lack of inspection by KSCB on the gradient level of UGD line has caused serious health hazards for the slum dwellers in shambu palya.

(iii) Non-maintenance of the drainage system

In Lingarajapuram Slum, The drainage system is a breeding ground for mosquitoes, the corporation authorities have not been maintaining these drains. The slum dwellers are forced to pay Rs. 15 per household for cleaning the clogged drains in the slums. Due to clogged drains, children in the area are always falling sick and slum dweller are forced meet the medical expenses as well.

In Nagina Palya slum, The state of drainage system is in a pitiable state. The poura karmikas come only once in 15 days and demand Rs. 2 from each household for cleaning the drainage. They dump all the waste in-front of the houses which is bad for the health of the slum dwellers. Slum dwellers have to bear the medical expenses when their sibling are affected with epidemics

In EWS quarters of Vinobanagar , each house has individual toilets with an open ended sanitary pipes.. As there is no septic tanks, human excreta flows through the open ended sanitary lines and drops behind the houses coupled with sewage water and garbage. This has caused huge environment crisis and diseases to the children.

Communicable diseases such as malaria, diarrhoea, acute respiratory diseases, tuberculosis are rampant in the slums due to lack of safe living environment in the slums

5. Non- Communicable Diseases

(i) Cancer

In Karnataka, about 45,000 cases of cancer are detected every year. The task force on health and family welfare says the prevalence of cancer is about

1.5 to 2.5 lakh cases in the state. Cancer is highest among the woman which is about one in twelve women. breast cancer, cervical cancer and uterus cancer are the most common incidences of cancer. Among these cervical cancer(21.5%) and breast cancer(18.6%) are the most common cancer sites among woman[8].

In the slums of bangalore city, the number of cancer patients who have been detected and undectected is increasing at phenomenal level. Majority of the slum woman are not even aware that they have been suffering from cancer.

(ii) Diabetes, Hypertension and CVD

Heart disease, high blood pressure, diabetes and obesity are much higher among the the city dwellers. 16% of the urbanites suffer from hypertension. The Cardio Vascular Disease(CVD) is now a major health problem with the bulk of it in developing countries. Ciggarette smoking and tobacco chewing all increase the risk of heart attacks as much as 300 percents.

One out of every 20 Bangaloreans may be a diabetic or on the way to becoming one[9]. Increasingly sedentary lifestyles, heavy smoking, alcoholism, poor food habits, obesity and the `thrifty gene' have resulted in, not only this garden city but the rest of urban India as well, to reel under a diabetes epidemic.

Various WHO reports point out that between 5-8 per cent of India's urban population (in some areas even above 10 per cent) are diabetics. In a city like Bangalore with a population of about 6 million, estimates are that between 2,50,000 to 3,00,000 are already diabetics. Another 1 lakh come from nearby areas. Many others have impaired glucose tolerance which could mean that they are within 4 to 5 years from actually becoming diabetics without lifestyle modification.

Due to high consumption rate of alcohol and tobacco, the rate of diabetes and CVDS are higher in the slums of bangalore city. Slums where Construction workers, loading and unloading workers, safai karmacharis and night soil workers are concentrated had known for high incidences of Diabetes and CVDs

6. Occupational Health

Atleast 50 - 70% of the workers in the unorganised sector residing in the slums are exposed to heavy physical workloads, leading to musculoskeletal disorders. Most affected in this category are construction workers, loading and unloading workers, Nightsoil workers, Municipal workers, woman involved in agarbathi rolling etc. Workers in the small scale industry are exposed to mineral, vegetable dusts like silica, asbestos and coal dust which are know to cause irreversible

[8] Study by Cancer Patients Aid Association, 2003
[9] Study by St Johns Medical College and McMaster University in Canada, 2002

lung diseases, TB, lung cancer and allergic reactions like asthama. The risk of cancer is high in the workplaces of small scale industry where 350 chemical substances have been identified as occupational carinogens, including benzene, hexavalent chromium, nitrosamines, asbestos,etc and ultra vilet and ionising radiations[10].

II. Health Care Infrastructure and Services

The Bangalore Mahanagara Palike(BMP) maintains about 30 maternity homes, 37 urban family welfare centres(UFWC), 25 dispensaries and 55 health centres. These public health infrastructure was built with financial assistance of the world bank under the Indian Population Project VIII. The health centres and UFWCs focus on health, nutrition education, entenatal/postnatal care, family planning, immunization mother & child, nutritional care of children up to the age of five. Apart from this, medical treatment of minor ailments and to act as referral units for the maternity homes was expected out of health centres and UFWCs. The maternity homes focus on delivery and medical termination of pregnancy(MTP) and laboratory tests. Maternity homes is also responsible for providing antenatal/postnatal care, family planning non-surgical care for children needing specialist attention and minor gynaecological procedures. The services of health centres, UFWCs and Maternity home is delivered for free.

The India Population Project - VIII

The India Population Project VIII (IPP VI) is a World Bank assisted project and has been in operation in the city from May 1994. The project aims at expansion of maternal and child health and family welfare services to the uncovered wards and population groups mostly the urban poor particularly the slum dwellers. The norm of IPP project is creation of one new health centre each for every 50,000 people. As planned, all the fifty five health centres have been created under the IPP VIII. The project also covers to improve the quality of health services being provided by the existing maternity homes of the BMP such as delivery, MTP and sterilization etc. for which health centres act as referral units.

The fifty five newly created health centres are presently under the administrative control of the IPP-VIII which supports the services of doctors, field staff and honorary link workers to the health centres. The Honorary link workers are volunteers residing in the slums, where they motivate mothers to utilize facilities

[10] Interview with Dr.Shashikala Manjunath, Occupational Health Specialist, Community Health Cell, ST Marathas Hospital, Bangalore, october 2002.

and services for ante-natal care, delivery family welfare, immunization. The BMP was able to build better health infrastructure with medical equipments,drugs and training for the technical personnel and public communication. IPP-VIII project was seen as project which improve quality of family welfare, maternal child care for the urban poor in the bangalore city

Corruption in the delivery of health care services

In 1999, the World Bank initiated process to ascertain whether the health care needs has been fulfilled and the impact of the IPP-VIII project on the health care system in bangalore city. The process took the form of consultation with different stakeholders/ beneficiaries in the selected slums of bangalore city. The findings underlines the fact that the health centres are assessed by the urban poor free of cost. In the case of maternity homes, maintained by BMP, none of its services such as sterlisation, MTP, delivery are available free of cost. The urban poor people were forced to pay bribes in majority of cases.

With the termination of World Bank Assistance in the year 2001, the IPP facilities has been integrated with the existing system of the BMP for routine operation and maintenance.

The surveys on maternity homes, UFWC and IPP Health Centres reveals that maternity homes are more popular among women for antenatal care than the other two providers. This indicates either a lack of awareness among the patients of the availability of these failcilties nearer their residences at the IPP Health centres or a reluctance to go to a new place. In either case there is a need to educate women on the advantages of using the IPP Health centre.

The level of corruption at Maternity homes is much higher than that of UFWCs and IPP Health Centres. One of the reasons for this could be that UFWCs and IPP Health Centres do not involve admission. The reason for which bribes are paid by most patients are for seeing the baby(69%) and for the delivery itself(48%). Other services like injections, family planning medicines, etc are also privided for payment of bribe but the extent is not so large. As far as the average amounts paid are concerned they are quite large for seein the baby and for delivery(Rs. 361 and Rs. 277 respectively) while other bribes are smaller in value.

Referral Role to Maternity homes by UFWCs and IPP Health Centres

Patients who had been to maternity homes were asked who referred them there. The response show that most of them came there on their own(68%), some were recommended by friends and relatives(8%) while 20% had been referred by IPP Health Centres and 4% by UFWCs.

Among patients who visited UFWCs and IPP Health Centres, 63% and 64% said they referred to maternity homes for delivery. Of these 81% and 67% went for their delivery to maternity homes from UFWC and IPP Health Centres respectively.

Health services to the poor women

BMP maternity homes is the only decentralised set of health facilities in bangalore that are accessed by relatively low income women and children. A network of outreach centres has now been created through IPP8 to expand and further strengthen the services of the maternity homes. While this expansion and upgradation of the health facilities for the poor needs is appreciated, it is important that careful thought is given to their proper utilisation, maintenance and effectiveness.

The following are the findings of the survey conducted in the year 2000[11]

- The overall satisfaction of patients was the lowest with the services of the maternity homes.
- Only a third rated them as good while 71% and 60% considered IPP centres and UFWC respectively as good.
- Only 39% of the patients of the maternity homes claimed that they received all medicines free as opposed to 63% in IPP centres and 61% in UFWCs. Maternity homes also lead in taking payments for injections. But the staff say that medicines are given free to all patients.
- Cleanliness of toilets is an indication of the standards of hygiene and sanitation. Here patients rated maternity homes the lowest (43%) in contrast to IPP centres (83%) and UFWCs(61%)
- Maternity homes were rated the lowest also in terms of staff behaviour towards patients. But the gap between them and IPP was much smaller in this case.
- The most distressing finding concerns the prevalence of corruption. About 90% of the respondents reported paying bribes for one service or other at maternity homes at an average of Rs. 700 each. The 70% pay for seeing their own babies. One out of two pay for delivery.

If a poor woman paid for all services, it would have cost her over Rs. 1000 for a delivery. It is reported that a nursing home might give her hassle free and better quality service for Rs. 2000. A rough estimate of the bribes being paid in all these

[11] User Feedback Survey by Public Affairs Centre in colloboration with Sumangali Sevashram, REDS, MAYA, Citizens Action Group and Community Health Cell

facilities may be between Rs. One and two crores annually. A similar estimate based on the finding that 90% of the women pay about Rs. 700 at the maternity homes would put the total amount of bribes paid at about Rs. 1.6 crores. The annual emoluments of the staff at the 30 maternity homes also amount to about Rs 2 crores.

Report on Health of the urban poor held on Peoples Health Day – 7th April 2003
At Ashirwad Bangalore, facilitated by Community Health Cell and KKNSS

Report by : S.J.Chander

Background

World Health Organization (WHO) having recognized that the health services expected by the people was not being provided, in 1997 during the World Health Assembly called for a revolutionary approach In Health Care that would enable the citizens attain a level of health that will permit them to lead a socially and economically productive life. In 1978 in the conference held in Alma Ata, Russia, Health For All by 2000 AD was declared. Primary Health Care approach evolved based on the experiences of countries like Sri Lanka and India was suggested as the best way to attain the goal. Services based on PHC approach were developed over the years for the rural poor but to far the urban poor the services available were family welfare and family planning.

He said the PHC approach though initially experienced some gains, gradually moved from comprehensive health care to more a selective primary health care approach. Pulse polio programme can be given as an example. National Health Policy 2002 draft is out and it is evident in it the shift. Process of globalization and influences of various lobbies are some of the factors that have had negative effect on people health. Of late the trend is moving more towards privatization.

This year is the silver jubilee of the Alma Ata declaration, it appears that WHO and the governments have forgotten the goal Health For All (HFA) by 2000 AD. Jan Swasthya Abhiyan (JSA) in India, known as People's Health movement internationally believes that it is the comprehensive health care that is going to help people attain the level that was envisaged by WHO during the declaration. It is time that both the government and the people's organization work together to achieve Health for All now!

Dr. Mala Ramachandran, Director, Urban Health Training and Research Center, Bangalore who was invited to share on the health services available for the urban poor said, approximately there are 15 lakhs people live in the slums of Bangalore. Population growth is the cause of the state of affairs in the slums. Usage of MCH services and Immunization coverage is low. Problems like cancer, diabetes, hypertension is prevalent. HIV AIDS and Tuberculosis are the other problems of concern to the urban poor. Safe drinking water and sanitation continue to be inadequate. During the response to Dr. Mala's presentation, the participants said, despite the efforts to control corruption. It is still rampant. There was concern among the participant regarding the removal of Link Workers who were working at slum level.

Followed by Dr. Mala's presentation, Mrs. Ruth Manoramma of Women's Voice shared urban poor do not have policy to address their needs. She said national policy of urban poor is being developed. The present family welfare programmes exclude men from the service coverage. Regarding sanitation needs, she said 70% of the Indian population still

does not have toilets. Women are the ones who are affected more due to lack of toilet facilities. From the 9th five-year plan it was observed the budget for health being decreased and budget for social welfare continued to face cut. The critiques have said the following: Public sector is moving towards privatization, public sector budget faced cut. commodification of health care, population gets major focus and distortion of priorities. Regarding her suggestions to change the scenario, she said the following:

1. We should demand for comprehensive primary
2. Introduction of barefoot doctors cadre and youth for prevention HIV/AIDS
3. Recognize urban health as an important component in Health Care services
4. Obtain information regarding health care services and disseminate widely among people
5. People should demand for transparency and accountability with the govt. services.
6. There is need to understand socio cultural and economic dimension of the causes of the illnesses.

Followed by Mrs. Ruth's presentation Ms. Preetham of Janagraha shared about their work in developing indicators for the health services. She said at present Jangraha is involved in the following three campaigns: a. ward work campaign. b. Proof campaign, and 3. Ankoor, which focuses on the services of SJSRY. They approach they have adopted is budget analysis, in which they analyze the budget allocated. actually spent and the quality of service. As an example she gave the education budget of the MBP when worked out the equation, the total cost per child per year works out to Rs. 29,000. She said the output for such a high investment is unacceptable. She said without information based on evidence objective discussion is not possible with the service providers and performance indicators help us demand accountability. At present she said they are experimenting with the approach: collect information, analyze, and organize management dialogue for improvement with education and heath care sectors of BMP.

Mr. Madhusudhan of KKNSS concluded the meeting with vote of thanks. It was decided at the end of the meeting to form a forum consisting of voluntary organization working with the urban poor for identifying and addressing the issues of concerns to urban poor under Janaarogya Andolana.

Madhu30@vsnl.net

Seminar on

HEALTH FOR ALL BY 2000 AD!
URBAN POOR WHERE ARE WE? HOW CAN WE MOVE FORWARD?

Date: 7th April 3, 2003
Time: 10.00 am to 1.00 p.m.
Venue: Ashirwad, No.30, St. Marks road cross
Bangalore – 560 001

Objective: A the end of the programme the participants will be able to:

1. Understand Health care facilitates available for the urban poor in Bangalore.
2. Identify areas of concern ~~for collaboration~~ and areas
3. evolve an action plan to address the areas of concern.

PROGRAMME

Time: 10 .00 a.m – 1.00 p.m.

Chairperson: Dr. Samuel Paul of Public Affairs Centre, Bangalore.

Introduction:	S.J. Chander of Community Health Cell	10.00 a.m to 10.10 a.m
Chairperson's Address	Prof. Samuel Paul	10.10 a.m – 10. 30 a.m
	Tea break – 10- 30 – 10.45.	
Presentation:	Health care services for the urban poor by Dr. Mala Ramachandran, Directror, Urban Health Reserch and Training Centre, Bangalore Mahanagara Palike	10.45 a.m – 11.45. am
Lessons learnt:	Advocating for the urban poor Mrs. Ruth Manoramma, Women's Voice Bangalore.	11.45 am – 12.00 noon
Discussion:	For identification of areas of concern and action plan, Facilitated by	12 noon – 1.00 p.m.
Vote of thanks	Mr. Madhusudhan of KKNSS	

16th Cross
Malleswaram
Bal 3. Opp to Vidya Soudha
Bangalore

3rd April 2003

Dear friends

Greeting from Janaarogya Andolana!

Subject: Peoples Health Day (World Health Day)

" Health For All by 2000 AD"
Urban poor, Where are we and
How can we move forward?

Health for all by 2000 AD is a familiar slogan to many people who are involved with health care services with the people. It is 25 years since the Declaration was made, in which all member countries of the World Health Organization signed and made a commitment to work towards achieving Health for All citizens using the Primary Health Care approach. Another World Health Day has come with the theme ".Healthy Environment For Children" the focus on comprehensive is missing.

It would appropriate, if we who are concerned about the Health and Development of the urban poor meet and plan how we can go forward in the coming year April 2003 to March 2004. There will be a presentations on the experiences of the health service providers for the urban poor and from the Bangalore Mahanagara Palike. **Dr. Mala Ramachandran Director, Urban Health Research and Training Institute** will make the presentation.

We hope the deliberations would help us draw up an action plan, which would help address health problems of the urban poor with the Primary Health Care approach. If you are interested, please join us at:

Ashirvad
No. 30, St. Marks Road Cross-,
Bangalore- 560 001
Phone: 2210154

On Monday the 7th April,
From 10. a m- 1.00 p m

Yours sincerely

S.J.Chander
For Janaarogya Andolana

3rd April 2003

Dear friends

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No. 30, St. Marks Road Cross-,
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On Monday the 7th April,
From 10. a m- 1.00 p m

Yours sincerely

S.J.Chander
For Janaarogya Andolana

VOLUNTARY ORGANIZATIONS WORKING IN AND AROUND BANGALORE

SL.NO	NAME OF ORGANIZATION AND ADDRESS	CONTACT PERSON	TELEPHONE NUMBER
1.	REDS Rag pickers education and development society 14,Curly street Langford town Bangalore – 560 0027	Mr. Joe Paul Reds @ vsnl . net -	22214247 Not attending
2.	MAYA, Movement for youth Alternatives 111, 6th main 5th Block Jayanagar Bangalore – 560 0041	Mr. Solomon mayaindia @ vsnl . com	6658134 6346053 Rashmi
3.	BOSCO B, street 6th Cross, Gandhinagar Bangalore – 560 009	Fr.Verghese	2253392 –
4.	**Maithiri Sarvaseva Samithi** 1300D I cross, I Main New Thippasandar HAL III stage Bangalore – 560 075	Mr. Anslem Rozario msss@vsnl . com .	5255543 6681244 able
5.	**Women'sVoice** 47/1 St. Marks road Bangalore – 560 001	Mrs. Ruth Manorama Hemalatha	6630262
6.	**Paraspara** 71/2 First Floor 7th Cross, Bandappa road Yeswanthpura Bangalore –	Venkatesh	3472701
7.	**CWC Concern for the Working Children** 303/2 LB shastri nagar vimanapura post Bangalore – 560 017	Nandana Reddy	3234270
8.	**YMCA Young Men Christian Association** 6 Infantry road Bangalore – 560 001	Joseph Chelladurai : 22118487 phone?	55854934
9.	Asha Deep Montfortian Society 7/1 Venkatappa road Tasker town Bangalore – 560 051	Sr. Lauret Marie	2864113
10.	APD Association of people with disabilities 6th Cross Hutchins road Hennur Main road Bangalore – 560 084	Mr. V.S.Basvaraju Kamakshi ablehand@vsnl.com	5475165 5470390
11.	APSA Association for Promoting Social Action Nammane Annasandrapalya Vimanapura post Bangalore – 560 017	Dr.Kshitij or Mr.Lakshapathi apsa bangalore @ vsnl . com	5232749 94
12.	World Vision of India 55,Lazor road Cooke town Bangalore 560 005	MR. Vijayakumar Nithya jeeva-India ADP @ WVI . org	5476382 6785764
13.	KKNSS Karnataka Kolegiri Nivasigaia Samukta Sanghatane 6th cross, Pukkraju layout Bannerghatta main raod Audugodi post Bangalore	Mr. Pakkirsamy or Mr.Deenadayalan 5 people attending 8 people –	22238739

14.	St. Marthas Hospital Community Health Department Nrupathunga roaad Bangalore – 560 009	D. Shakuntala	2257081
15.	St. Johns Medical college Community Health Department Sarjapur road Bangalore – 560 034	Dr. Dara Amar daraamar @ vsnl . net	5530 724
16.	DEEDS VI main S.K. Garden Benson town Bangalore – 560 046	Mr. Thyagarajan patmcind @ bgl . com . vsnl . net . in	333 ~~1783~~ (2) 8317
17.	Deena Seva Sangha Rasildar street Sheshadri puram Bangalore	Prof.Ramarao	
18.	**FEDINA Navachena** Munikapana Garden II cross Ramasamy palya Kammanahali Bangalore – 560 033		546 3933
19.	**Community Health Department** Ambedkar Medical College Kadukondanahalli Bangalore – 560 0043		
21	**Bangalore Medical Services Trust,** New Tippasandra Main Road, HAL III Stage, Bangalore – 560 075	**Dr. Lata jaganathan**	**Phone:** 5287903
22	**Sanjeevini Trust,** 57, Langford Road, Richmond Town, Bangalore – 560 025.	**Dr. VedaZachariah**	**Phone:** 2212530
23	**Freedom Foundation,** 9/30, Karam Chand Layout, Hannur Main road, Lingarajauram, Bangalore – 560 084.	**Mr.Ashokarao**	**Phone:** 5479766
24	**Madhyam,** No.1, 10th Main 10th Cross Vasantha Nagar, Bangalore – 560 052	**Phone: 2281983** madhyamb @ vsnl . com	5497358
25	**Christian Medical Association of India,** III Floor, IIVS Court, 21, Cunningham Road Bangalore – 560 052.	**Phone:**	**Dr.Shobha Yohan,**
26	**ICDSS** Ist cross Vivekananda nagar Bangalore – 560 033		

27	**Bangalore Multipurpose Social Service Society** Archbishop House 4626, Basweshwara road Bangalore – 560 046		
28	**Bangalore Children's Hospital** 5th Stage Rajarajeswari Nagar Bangalore – 560 039	**Dr. Nandini Munkur**	8430552
29	**Karnataka State Council for Child Welfare –** 3rd Cross Nandidurg road Jayamahal Bangalore – 560 046		3330846
30	**St. Lukes Ragpickeres Welfare Programme** Pampa mahakavi road Chamrajpet Bangalroe – 560 018		604065
31	Convener **Disability Net Work** C/o ADD India 19th Cross Banashankari II stage Bangalore 560070	**Mr.Ramachandran**	
32	**Griha Karmika Okkoota** 2,Millers road Bangalore – 560 046		33304338/3330838
33	**Jana Sahyog** Urban Resource Centre 5/b 4th Block Ranka park apartment Lalbagh road Bangalore – 560 027		22243723
35	**Bharat Gyan Vignana Samithi** **C/o Electro Chemical Society of India,** Indian institute of science campus Bangalore – 560 012	Dr.Prakashrao Mr.Basvaraju	3600384
37	**Banashankari Consumer Protection Society** 9th Main 27th Cross Banashankari II stage BANGALORE -		
38	**Society for International Development** Bangalore Chapter Railway parellel road Nehru Nagar Bangaloro – 560 020		3364689/3441752

39	**South India Cell for Human Rights Education and Monitoring** **SICHREM** Anjanappa complex Hennur road St. Thomas town Post Bangalore 560 084		5464151
40	**Action on Disability Development - India** 19th Cross Banashankari II stage Bangalore - 560070	**Mr.Ramachandran**	
41	**VIMOCHANA** C/o Angela Ist A cross 16th B main HAL II stage Banaglore – 560 008		5269307/5278628 — 54927782
42	**Society for Developmenet of Women and Children** 271, Rama leela VV Puram Bangalore 560 0043		
43	**P&P Group** 13th Cross road Wilson Garden Bangalore – 560 027	**Mr..Padaki**	
44	**Voices** 165, First Floor 9th Cross, I stage Indranagar Bangalore – 560 038	**Ashis Sen**	**5213902** **voices@vsnl..om**
45	**Karnataka Slum Clearence Board** Rasildar street Sheshadripuram Bangalore – 560 020		
46	**Ecumenical Christian Centre** P.O.Box.11 Whitefield Bangalore 560 066		
47	**Churches' council for child and youth care in south India** Lavelle road Bangalore		2210098/2211412
48	**CIVIC** South Block Manipal Centre Dickenson road Bangalore -= 560 0042		**5587752**

49	**Samraksha** II floor Royal corner Lalbag road Bangalore – 560 027		
50	**Medico pastrol Association** Pottery road Bangalore – 560 005		5577375
51	**CBR Forum** 11th main BTM layout Stage I Bangalore – 560 029		6684218
52	**Intervention India Pvt Ltd** 2, Haudin house Ulsoor Bangalore – 560 042		5599092
53.	**Deena Seva Sangha** School health Programme Sevaashram (Gandhi School) 5th Main, Sriramapuram Bangalore – 560 021		**3358562/3363661**
54	**Action Aid India** Disability Division Action Aid India, 3, Rest House Road, Bangalore – 560 001.	**Dr. Pruthvish**	
55.	**Joint Women's Programme** Miller road Post Box 4600 Bangalore 560 001		
56	**Outreach** 109 coles road Frazer town Bangalore 560 005		5545365
57.	**Indian Society of Health Administration** 104 (15/37) Cambridge road cross Ulsoor Bangalore – 560 008		5574297/5531979
58.	**Institute of Social studies Trust** Shreeshyla 42, 4th Temple street,15th Cross Malleswaram , Bangalore – 560 003		**3323850/3312861**

59	**Catholic Health Association of India – Karnataka,** C/o. St. John's Medical College & Hospital, Sarjapur Road, **Bangalore – 560 034.**	**Sr. Elize Mary,**	**Phone No.:** 98440 - 87344
60	**Voluntary Health Association of Karnataka,** No. 60, Rajini Nilaya, II Cross, Gurumurthy Street, Ramakrishna Mutt road, **Bangalore – 560 008.**	**Ms. T. Neerajakshi,**	Phone No.: 5546606 vhak@vgl.vsnl.net.in
61.	**Family Planning Association of India,** Bangalore Branch, 26, Sri Nivasa, D. N. Ramaiah Layout, P G Halli, Bangalore – 560 020. Phone No.: 3360205	**Ms. Shanta Baliga,** President,	
62	**National Alliance for People's Movement – Karnataka,** No. 24, michaiel Palya, New Thippasandra Post, **Bangalore – 560 075.**	**Ms. V. Gayathri,**	Phone No.:
63	**Madhyam Communications** 10th Cross, 10th main Vasanth Nagar Bangalore – 560 00		**2281983**
64.	**Prakruti** 79,kariyanapalya Lingrajapuram Bangalore – 560 084	**Promod John** prakruti2000@vsnl.com	5469550
65.	**New Horizon trust for disabled** 354, 10th main 100 feet road Dodda Banaswadi Bangalore – 560 033	**Ms. Dorothy** new horizon@eth.net	5454653

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Phone: 530 3354/ 5369550

Mr. T.Yoheshwaran
V. Hariharan.

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Bangalore – 560 062.

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Mails sent on Fri/Sat
Amount 5/4/03

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3rd April 2003

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Subject: Peoples Health Day (World Health Day)

" Health For All by 2000 AD"
Urban poor, Where are we and
How can we move forward?

Health for all by 2000 AD is a familiar slogan to many people who are involved with health care services with the people. It is 25 years since the Declaration was made, in which all member countries of the World Health Organization signed and made a commitment to work towards achieving Health for All citizens using the Primary Health Care approach. Another World Health Day has come with the theme " Healthy Environment For Children" the focus on comprehensive is missing.

It would appropriate, if we who are concerned about the Health and Development of the urban poor meet and plan how we can go forward in the coming year April 2003 to March 2004. There will be a presentations on the experiences of the health service providers for the urban poor and from the Bangalore Mahanagara Palike. **Dr. Mala Ramachandran Director, Urban Health Research and Training Institute** will make the presentation.

We hope the deliberations would help us draw up an action plan, which would help address health problems of the urban poor with the Primary Health Care approach. If you are interested, please join us at:

Ashirvad
No. 30, St. Marks Road Cross-,
Bangalore- 560 001
Phone: 2210154

On Monday the 7th April,
From 10. a m- 1.00 p m

Yours sincerely

S.J.Chander
For Janaarogya Andolana s

Seminar on

HEALTH FOR ALL BY 2000 AD!

URBAN POOR WHERE ARE WE? HOW CAN WE MOVE FORWARD?

Date: 7th April 3, 2003
Time: 10.00 am to 1.00 p.m.
Venue: Ashirwad, No.30, St. Marks road cross
Bangalore – 560 001

Objective: A the end of the programme the participants will be able to:

1. Understand Health care facilitates available for the urban poor in Bangalore
2. Identify areas of concern.
3. Evolve a collaborative action plan to address the areas of concern

PROGRAMME

Time: 10 .00 a.m – 1.00 p.m.

Chairperson: Dr. Paresh Kumar, Community Health Cell!

	Introduction:	S.J. Chander of Community Health Cell	10.00 a.m to 10.10 a.m
	Presentation:	Health care services for the urban poor by Dr. Mala Ramachandran, Directror, Urban Health Reserch and Training Centre, Bangalore Mahanagara Palike	10.10 a.m. – 11.10. a.m.
	Tea Break- 11.10- 11.30		
	Lessons learnt:	Advocating for the urban poor:Mrs. Ruth Manoramma, Women's Voice Bangalore.	11.30 am – 11.45
	Discussion:	Identification of areas of concern and action plan. Facilitator: Mr.Ramesh Ramanathan, Jangraha	11.45 p.m. – 1.00 p.m.
	Vote of thanks	Mr. Madhusudhan of KKNSS	1.00 p.m

PUBLIC AFFAIRS CENTRE

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07 March 2003

Dear friends,

SUB: KRIA FIELD ASSESSMENT -2ND REVIEW

We thank you for your continued interest and participation in our efforts to effectively secure the Right to Information in Karnataka. We hope you have been able to resubmit your applications to the Competent Authorities at BMP, as decided at our last meeting on 30th January 2003.

We would like to inform you that a team from PAC and CHRI, Delhi had a meeting with Ms. Vatsala Watsa, Secretary to Government, Department of Personnel and Administrative Reforms to update her on the status of field assessment. She was very supportive of our initiative and has expressed keen interest in the findings of the assessment, while also assuring prompt action on the recommendations that will be formulated based on the assessment.

In view of this, there is an urgent need to complete the field assessment, analyze the findings and formulate recommendations at the macro level. This would help streamline the implementation of the provisions of KRIA. Furthermore, to stimulate greater transparency in the functioning of BMP, we must ensure that a large number of KRIA applications are submitted to BMP. However, in order to formulate meaningful and scientific conclusions from the assessment, we may have to file additional applications covering a wider range of public authorities.

In order to review the status of pending applications and to finalise our strategies / action plan for the final round of KRIA applications, we invite you to participate in the **" KRIA Volunteers Meet" being organised on 13th March, 2003 at PAC Office between 10.30 a.m. and 1.00 p.m.** Please bring copies of all the applications you have filed thus far as well as the completed field observation schedule.

We are looking forward to your Continued Support and Participation

Warm regards

Sincerely Yours

Manjunath Sadashiva
Chief Programme Officer

10/3/03

Encl: Where did our money go?
A short compilation of Parivarthan's struggle against corruption using the Delhi Right to Information Act

912 — 10/3/03

Where did our money go?

Funds meant for development do not reach their destination and are siphoned off in between. Rajiv Gandhi, former Prime Minister, once said that only 15% of the funds reach the beneficiaries.

A social audit was conducted by Parivartan, a citizen's initiative, along with the local residents of two resettlement colonies of North East Delhi, namely Sundernagri and New Seemapuri for development works undertaken by the Engineering Department of the Municipal Corporation of Delhi (MCD) in these two resettlement colonies between April 1, 2000 and March 31, 2002. Only works pertaining to construction of roads, lanes and drains and installation of handpumps were taken up for this social audit - a total of 68 contracts worth about Rs 1.42 crores.

On 14th December, a public hearing (jan sunwai) was organized in Sundernagri by Parivartan along with the National Campaign for People's Right to Information (NCPRI) and Mazdoor Kissan Shakti Sangathan (MKSS) of Rajasthan to discuss publicly the works audited. The public hearing was attended by almost 1000 people including local residents of the area, journalists and eminent personalities such as Justice P B Sawant, Aruna Roy, Prabhash Joshi, Viond Mehta, Bharat Dogra, Shekhar Singh, Arundhati Roy and Harsh Mander. In the public hearing, the contracts were read out and local residents testified as to whether or not the work was undertaken, and if it was undertaken whether it was done fully or was left incomplete.

Out of the 68 works audited and discussed in the public hearing, calculations of estimated misappropriation of funds have been done for 64 works worth Rs 1.3 crore. In these 64 works, the total amount of embezzlement found on account of missing items/works is approximately Rs 70 lakhs (i.e. items or works worth about 70 lakhs do not physically exist at all in these 64 works). This figure does not include the amount embezzled on account of quality issues like the quantity of cement used etc.

Some examples of missing items are as follows:

- 29 handpumps with electric motors were supposed to be installed under 10 contracts. However, residents of this area reported that only 14 handpumps had actually been put. The rest of the handpumps were not installed at all, according to the residents. Electric motors have not been installed in even a single case. Loss on account of missing handpumps and missing motors is roughly estimated at Rs 7,85,965.
- Whenever a new street is made, new iron gratings are also put on the drains going across the street. Out of a total of 253 iron gratings weighing 27,557 kg, for which payments have been made, only 30 iron gratings weighing 3,136 Kgs were actually put, according to the residents. The loss on account of this is roughly estimated at Rs 7,30,952.
- Whenever a new street is made, the drains on both sides of the street are also supposed to be demolished and remade afresh. However, this is rarely done. Either

no work is done on the drains or at best, the level of the existing drains is raised by just one brick. Out of a total of 35 cases examined, payment has been made by MCD for construction of fresh drains in all these cases, however fresh drains were not made even in a single case. In 19 cases, the level was raised by one brick while in the rest of the cases, no work was done at all on the drains. Loss on account of this has been roughly estimated at Rs 13,85,175

- The thickness of cement concrete layer in the streets should be 10 cm, according to the bills. However, the thickness, in most of the cases was found to be 5 cm, as found after digging. This is the most expensive item in such contracts. Loss on this account has been roughly estimated at Rs 8,33,935
- There are some roads and streets, which exist only on paper. The residents of these areas informed that these streets/roads have not been made at all. In some cases, measurements have been shown in excess of the actual work done. Loss on account of missing roads and streets is roughly estimated at Rs 12,92,398.
- In two instances, it was discovered that payments have been made twice for the same work i.e. the work was done once but the bills were raised twice for the same work.
- Two layers of stone aggregate are supposed to be put before bitumen mix is laid in the construction of premix roads. However, out of 8 cases of road construction, in 6 cases only one layer of stone aggregate was put and in the other two cases, not even a single layer was put.
- A layer of red bajri is supposed to be put in the construction of roads. This has never been done in any of the roads.

It would require elaborate tests to make comments on quality issues. Such tests are quite expensive. Two such tests were done for two works at Shriram Institute –one for a cement concrete lane and the other for a bitumen premix road. The cement content was found to be one fourth of the contracted amount (it was in the ratio of 1:5:15 against the prescribed ratio of 1:2:4, where one part is of cement, two parts are for coarse sand and 4 parts are for stone aggregate). The bitumen content was found to be 20% less than the contracted quantity. The results of these tests are eye-openers and a sufficient reason for the government to order tests for the rest of the works.

During jan sunwai, the supporters of local political leaders including the MLA tried to disrupt the proceedings at least thrice. But the public support to the jan sunwai process was so overwhelming that their efforts did not succeed.

Effects of jan sunwai:

This social audit was done for works carried out by just one department of the MCD over only a two-year period in a geographical area, which is smaller than one ward. Delhi has 134 wards. The embezzelment of Rs 67 lakhs, thrown up by the social audit and the public hearing, is therefore a very small fraction of the total amount of funds misappropriated in the name of 'development' in Delhi.

The jan sunwai at Sundernagari has demonstrated the proportion of embezzlement and the urgency with which, the issue needs to be tackled. It clearly demonstrates that most of the time, it is not the inadequacy of funds but leakages, which are responsible for poor development.

The jan sunwai has had tremendous impact on the psyche and morale of the people of Sundernagari and Seemapuri. The people are now aware of the amount of money that was supposed to be used, the works that were supposed to have been executed and what exists in reality. The community, for the first time witnessed, that it is possible to hold the government accountable in full public glare in this manner.

Mohalla Samitis (Local Area Committees) are now being formed in Sundernagari for each block. These would contain representatives from each street in that block. These Samitis would then monitor the execution of any civil work in their block by obtaining relevant documents from MCD. It was also seen during the process of social audit that a number of such works had been executed, which had no utility for the community. The Samitis, would therefore, also decide the requirements of their blocks and communicate it to the government at regular intervals, so that the funds could be used for works useful for the community. It is important that public actively participates in deciding which works should be carried out in their area and they also monitor the execution of these works. It will go a long way in ensuring proper utilization of funds.

The jan sunwai has also had great impact on the local bureaucracy. After the jan sunwai, the officials have realized that the records could be scrutinized by the public any time and it would not be easy for them to swindle funds any more. The officials are also quite scared of the consequences that would follow this jan sunwai once the detailed report of social audit is presented to the government. The officials are far more responsive and courteous in their dealings with the public of this area now.

It is strongly felt that if people start holding the government accountable in their local areas by holding such jan sunwais on a large scale, it would mean the beginning of an effective anti-corruption civil society movement. Parivartan's immediate efforts would be directed towards spreading it to every nook and corner of Delhi.

Parivartan, E-109, Pandav Nagar, Delhi-92. Ph: 91-11-22063389, 22064281. E-mail: parivartan@parivartan.com

Health For All by 2000 AD

Urban Poor where are we, how can we move forward?

World Health Day- (Peoples Health Day) 2003
Ashirwad. 30. St. Marks road Cross, Bangalore- 560 001

Introduction

World Health Organization defines health as a state of complete physical, mental and social well-being and not merely absence of disease or infirmity. The influencing factors for achieving this lie within and outside in society where the individual lives. The determinants of health can be classified under the following areas: biological, behavioral and socio cultural, environmental and social and economic conditions.

WHO having recognized that the health services expected by the people was not being provided, in 1997 during the World Health Assembly, it called for a social target by the all the 134 member countries then to work towards helping the citizens attain a level of health that will permit them to lead a socially and economically productive life.

Further failures faced made WHO-UNCEF in the conference held in Alma Ata, Russia in 1978, call for a revolutionary approach to health care. The conferences called the governments to accept the goal " Health for All (HFA) by 2000 AD" and adopt primary health care as an approach to achieve it. Health for All meaning health is to be brought with the reach of any one in a given community. After the declaration, the Indian government came out with plans to achieve Health for All through the 1983 National Health Policy.

This approach though initially experienced some gains, gradually moved from comprehensive health care to more a selective primary health care approach. Pulse polio programme can be given as an example. National Health Policy 2002 draft is out and it is evident in it the shift. Process of globalization and influences of various lobbies are some of the factors that have had negative effect on people health. Of late the trend is moving more towards privatization. The services available for the urban poor over these years have been family welfare and family planning focused.

This year is the silver jubilee of the Alma Ata declaration, it appears that WHO and the government have forgotten the goal HFA. Janswasthya Abhiyan (JSA) in India Known as People's Health movement internationally believe that it is the comprehensive health care that is going to help people attain the level that was envisaged by WHO during the declaration.

JSA was launched in the year 2000 in Dhaka, Bangladesh where delegates from 90 countries gathered for the International Peoples Health Assembly. This movement in Karnataka it is known as Janaarogya Andolana. It is the desire of JAA to bring together health care service providers, policy makers, voluntary agencies and people for working towards achieving "Health for All now"

Primary Health Care

Primary health care is defined as essential health care based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-determination.

Components of primary health care
(Declaration of Alma Ata (7) USSR, 1978

Following are the components identified at the Alma Ata conference:

1. Education about prevailing health problems and methods of preventing and controlling them.
2. Promotion of food supply and proper nutrition
3. An adequate supply of safe water and basic sanitation.
4. Maternal and child health care including family planning
5. Immunization against infectious diseases
6. Prevention and control of endemic diseases
7. Appropriate treatment for common diseases and injuries
8. Provision of essential drugs.

Health care facilities and process of urbanization

It is presumed that urban poor do not lack health care facilities, as most of the health care facilities are concentrated in the urban areas. This may be true but how much of the facilities are really accessible, available and affordable to urban poor is the question for which one must find an answer.

The process of urbanization in Bangalore further added pressure on the limited resources available to them. The existing facilities; 38 maternity homes, 6 referral hospital, 55 health centers and 19 family welfare clinics are barely sufficient for the 12 percent of the five million residents of Bangalore city. The recent Hindu daily report on 4th January 2003 said the bulk of the budget goes for solid waste management and salaries of the staff at the dispensaries and hospitals. The report also said that essential drugs are not available for poor free of cost and the poor cannot afford to purchase them from private chemist shops. These services may be geographically accessible but doest it cater to all people living in the slums is another question that needs a satisfactory answer. Regarding availability, it is the private practitioners who are available at time of need particularly after they come back from work.

Living condition

The living conditions where the urban poor are living in most places are far below the standard for human habitation, lacking potable drinking water, facility for disposal of solid and liquid waste and housing. The Hindu reported quoted above confirms this. The needs expressed by the slums dwellers according to the report are: safe drinking water, toilet, underground drainage, trauma care, education and prevention of alcoholism and empowerment of women to resist alcoholism. The report also emphasized the need for creating better job opportunities and motivation of better living conditions. How can there be motivation for better living conditions when their place of habitation is (unauthorized) and people face the threat of evacuation any time. In the light of the problems faced by the urban poor where is the resource for better living condition? It is nice to suggest that they need preventive health care and income to purchase nutritious food. ***How can one talk about preventive health care in the absence of basic amenities like housing, water and*** sanitation?

Alcoholism

Alcoholism is another major problem that puts pressure on the limited income of the urban poor. The survival of the alcohol industry to a large extent depends on the poor. The major portion of the income that the man earns goes in for alcohol, depriving the families the money for nutritious food and educational needs. One of the serious consequences of alcoholisms is violence, particularly against women. Do we need more studies to confirm to get into action? When would there be a relief for the urban poor form this menace? Who would act for them? How long the government is going to continue with the excuse that prohibition would lead to consumption of spurious liquor. As the struggle continues one wonder is there a way out at all.

Increasing infrastructure development for providing curative care will not provide a long-term solution for the problem of the urban poor. There is need an immediate attention from the government to address the land issue by notifying the slums. This will help a few government bodies would come forward to provide the basic amenities thereby paving the way for promoting preventive and promotive health care. The problem of alcohol has to be addressed as the next priority. As action for demand reduction continues the government should bring prohibitory orders. Certainly there is a need for collaborative efforts by Government, voluntary organization and people for improving and strengthening the existing services and to identify areas needing intervention through advocacy and address them.

The present health care facilities available for urban poor which is family welfare and family planning focused should move towards a comprehensive primary health care, enabling people to take care of their own health not merely providing some services. It is hoped that this dialogue would help focus the discussion achieving this.

Prepared by:

S.J.Chander
Community Health Cell, Bangalore

PERFORMANCE INDICATORS FOR HEALTH

INPUT	OUTPUT	OUTCOME	EFFICIENCY	PRODUCTIVITY	EXPLANATORY
• Minimum Infrastructure Standard General Ward Labor Ward Operation Theatre (OT) Minor Operation Theatre Toilets Condition of toilet Bathrooms: -- Availability of hot water -- Availability of sewage system. Laboratory Waiting Area Patient Attendant Space Outpatient Area Availability of drinking water Linen Service Generator set Store Room Ambulance Service Quarters for Doctors and Drivers Telephone Service Privacy of examination area Fumigation • Minimum Equipment Standard. Availability of required Equipment in all rooms. • Drugs Availability of minimum essential drugs. Availability of emergency drugs.	• Number of deliveries Normal Caesarean and Assisted • Number of family welfare procedures. • Number of high risk pregnancies detected during labor / antenatal care • Number of immunizations against measles. • Number of admissions. • Number of admission slips. • Number of patients registered for postnatal care. • Number of patients registered for antenatal care. • Number of Medically Terminated Pregnancies (MTP).	• Number of maternal deaths. • Number of neo natal deaths. • Number of stillbirths. • Number of infant deaths. • Number of perinatal deaths. • Number of measles cases. • Number of deaths due to measles • Number of admission to number of admission slips. • Complaint redressal system. • Patient feedback forms. • Percentage of patients coming in for 3 postnatal check ups. • Number of patients registered for antenatal care prior to 12 weeks. • Number of days with stock outs of essential drugs.	• Downtime of key equipment. Autoclave. Laproscope. Refrigerator. Generator. Ambulance BP Apparatus Instrument Sterilisers Weighing Machine – Adult and Infant Incubators Boyle's Apparatus Pulse Oxinator Hysteroscopes • Time taken to fill up vacancies to sanctioned strength. • Nurse patient ratio. • Doctor patient ratio. • Full time employees per occupied bed. • Waiting time for patient. • Cost of drugs per patient (inpatient / outpatient). • Cost per inpatient day. • Cost per outpatient day.		• Staffing patterns. • Number of patients below the poverty line. • Inventory / Store management maintenance mechanism.

• Furniture. • Stationery for correspondences. • Staff (Sanctions, Vacancies and Absentees) Doctors Staff Nurses Auxiliary Nurse Midwives (ANM) Lab Technicians Peons Ayahs Sweepers Drivers Dhobhi's (Contracted) • Capacity Building Type of training programme. Periodicity of training. Number of people trained. • Financial Salaries budget Maintenance budget - Equipment Maintenance budget –Building Drugs budget. Equipment budget. Training Budget. Fuel and vehicle maintenance budget User fees Laundry budget Contractual Services budget Miscellaneous expenditure budget	• Number of complaints. • Number of outpatients per day. • Number of referrals. • Number of prescription slips issued • Number of visits by the health officer/ supervisor • Use of equipments	• Display board of available drugs. • Amount of user fees collected. • Bed occupancy rate. • Number of deaths due to sterlisation	• Utilisation of user fees. • Percentage of high risk cases among deliveries • Number of complaints received to number of complaints redressed		

Status of Health in the Slums of Bangalore City

By
Madhu Sudhan
Training Research and Documentation Unit
Karnataka Kolageri Nivasigala Samyukta Sangatane(KKNSS)
Bangalore

Introduction

Health is a complete state of Physical, mental and social well being and not merely the absence of disease of infirmity[1]. Access to health care was one of the indicator of measuring reduction in poverty of underprivileged masses in the rural and urban poor areas of the country. One of the important components of health care system of consists of : primary, secondary and tertiary care institutions, manned by medical and para-medical personnel. The Primary Health Care Infrastructure provides the first level of contact between the population and health care providers. Realising its importance in the delivery of health care services, the state and central government has started primary health centres[2].

About 30% of the India's population live in the urban areas. The health care system is much better compared to the rural areas. However , the urban migration has resulted in growth of slums. The slum population face greater health hazards due to over crowding, lack of sanitation, no proper access to drinking water and environmental pollution. Realising that the health infrastructure is insufficient due to the growth of urban population, the local government, state government and central government has built up urban health care facilities. But, there has no effort to provide well planned and organised, primary secondary teritary care services. Dispensaries, Primary Health Centres, Government Hospitals and Referral hospitals are the four tiers of the health care system in the urban areas in the country.

Urban Poor in Bangalore city

In Bangalore city, there are about 472 slums[3] in the Bangalore city. Of which 202 are declared under section 3F of the Karnataka Slum Areas Act 1973. The slum population in the declared slums will provided with basic amenities only the slum is declared. Therefore the number of undeclared slums in bangalore city is 270 on the lands owned by government agencies, private owners, railways ,defence lands etc., A more realistic figure came from the National Sample

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[1] . Definition by World Health Organisation
[2] .Tenth Five Year Plan Document on Health, Planning Commission of India, 2003
[3] . Commissioner , Karnataka Slum Clearance Board, March 2003

Survey, 49th Round, in 1993. Here, the slum population was estimated at 32.2 lakhs, making it around 23 per cent of the total urban population in the State. This study estimated the population of Bangalore's slums at 10 lakhs[4].

I. Health Status of Urban poor in Bangalore city

1. Malnutrition

About 70% of the children in the slums of Bangalore city suffer from malnutrition[5]. A significant reason for this is poverty many people cannot afford regular nutritious meals in the slums. In times of economic stress, this becomes frank malnutrition; the body under such condition is unable to resist disease and succumbs to it

Children in the slums suffer undernutrition : 1.Marasmus, which is wasting; frequent cause is underfeeding, diarrhea and infection;2.Kwashiorkor, marked by swelling of the body. Swelling is due to a fall in circulating proteins. Stunting (poor height gain) in the slum is the commonest type of malnutrition in childhood. Some children may be underweight. Both height and weight suffer due to malnutrition.

Anganwadi(ICDS)

Anganwadi is a community health programme for improving nutrition, health and pre-school education of children. At present, it covers the slums and other backward areas in Bangalore city. The target group is children under 6 years.

The target group is divided into two sub-groups, one below 36 months and the other above 36 to 72 months. The younger group stays at home with the mothers. So this programme is ineffective for the younger babies without home visits. The other group - above 3 years - is accessible in the Anganawadi (which is a balwadi and feeding centre). Anganwadis are held in the morning. The primary health centre is expected to undertake immunisation and health checkups in the ICDS programme. The anganwadi worker , who is usually a slum woman with some formal education, conducts teaching activities too. The helper woman does the cooking and feeds the children's. The functioning of the Anganawadis need to be reviewed jointly by the Government and NGOs and its co-ordination with Primary Health Centres. The low rate of immunization (except pulse polio) and malnutrition

[4] Karnataka Housing Revolution, Parvathi Menon in Frontline Magazine, Vol 19, Issue 13 June - July 5,2003

[5] Dr. Mala Ramachandran, Health Officer Bangalore Mahanagara Palika(BMP), World Health Day(April 7, 2003) at Ashirwad, Bangalore

in the age group of younger children in the slums reflects the effectiveness of Anganawadi network in the urban poor areas

2. Environmental Sanitation

Due to scarcity of pure and wholesome water supply, where water is not easily accessible, provision for waste disposal facility and sanitary latrine are in adeuqate. Poor housing conditions, poor personal hygiene, personal habits are causes morbidties in these areas. The inaccessibility to potable water is caused the high rise in the epidemics. The following are the two major causes for the inaccessiblity to water supply system.

(i). Unable to access due to high cost of water connection and service

In order to access the BWSSB water connection to the individual household, a deposit of Rs. 800 is fixed with an water meter attached for monitor the water consumption. The one-time connection charges prove to be an obstacle for many households, both in slums and other areas, in accessing formal connections. BWSSB has decided that certain elements of the connection charge, such as the number of sanitation points charged for(five), can be re-considered and reduced (to two) in view of the small size of houses in slums and low-income areas and the limited number of sanitary fixtures. This element alone can reduce the connection charge by Rs. 360.

The major issue with the slum dwellers is the tariff fixed by the BWSSB. The existing rate of 1 kilolitre of water is Rs. 6 for domestic consumption under consumption slab of 0-15,000 litres and Rs. 8 per litre for the domestic consumption slabs between 15001 to 25,000 slabs. The BWSSB argument for the recent hike in water charges is to cope with the increasing operational costs.

The slum dwellers have been demanding for fixation of subsidised rate for slums and much reduction from Rs. 6 for domestic consumption slab of 0-15,000 litres. On 27-12-2002, About 5000 slum dwellers staged protest rally in Bangalore city under the leadership of KKNSS, Women's Voice and AVAS for subsidised rate for water which was one of their demands. Now, BWSSB has started to experiment for providing subsidised rate for water supply to the slum dwellers.

On March 4 th 2003, BWSSB has started the process of providing subsidized water supply for the slum dwellers in Lingarajapuram Each household will be provided with one water tap, and for a family of five is expected to consume less than 7200 litres of water per month. . The new initiative will cover 1000 families by extending 50 percent concession on connection charges and service charges. The rates for connection charges are Rs. 800 per household and monthly payment of Rs. 115 for consumption of water.

But the majority of the slums in bangalore city are reluctant to accept the BWSSB package due to high cost of the connection and the monthly charge of Rs. 115. The slumdwellers expect the BWSSB to reduce the deposit and monthly charges by half and also a guarantee that the BWSSB's customers in the slums are exempted from future hike in water charges.

(ii). Absence/low capacity of network in the area

The newly formed wards of Bangalore city (from ward no 63 to 100) are out of the BWSSB network. It is estimated that 30% of the slums in the Bangalore city could not avail water supply connection due to absence of BWSSB network in the area. In these slums, the water crisis exist even though water supply is provided through by public taps with mini tank storage systems. Despite this there is acute water crisis in this area.

Chart - Slums of the wards where BWSSB network does not exist and partially exist

Ward No.	Ward Name	Slums	Absence of Infrastructure	Partial Infrastructure exist
1	HMT	12	✓	
12	Nandini Layout	5	✓	
13	Geleyara Balaga Layout	3	✓	
16	Kamalanagara	9	✓	
17	Vrishabhavatinagar	3	✓	
18	Kamakshipalya	3	✓	
19	Basaveshwarnagar	3	✓	
35	Marenahalli	3		✓
37	Amarjyothinagar	2	✓	
38	Mudalapalya	1	✓	
39	Chandralayout	10	✓	
41	Gallianjaneya temple	3		✓
52	Hanumanthanagara	3		✓
53	Srinagara	4		✓
54	Srinivasnagara	13	✓	
55	Padmanabhanagar	8	✓	

56	Ganesh Madira	13		✓
57	JP Nagar	5	✓	
65	BTM Layout	10	✓	
67	Kormanagala	5		✓
68	Ejipura	7	✓	
69	Neelasandra	7	✓	
72	Domlur	10		✓
73	Airport	15	✓	
74	JB Nagar	2	✓	
83	CV Raman Nagara	1	✓	
84	Beniganahalli	8	✓	
85	Sarvagnanagar	13		✓
87	Lingarajapuram	6	✓	
88	Banaswadi	2	✓	
89	Kacharakanahalli	3	✓	
90	Sagayapuram	4		✓
93	DJ Halli	3	✓	
94	Kadugondanahalli	4	✓	
95	KB sandra	4	✓	
96	Hebbal	6	✓	
99	Aramanenagara	4		✓
100	Sanjaynagar	12	✓	
	Total	299	243	56

Source: - BWSSB: ward wise list of its existance of partial or absence of water supply Infrastructure.
BASCIS - list of slums.

Health experts agree that if safe drinking water supply is provided to the slum dwellers, a substantial improved in the health status of the urban poor can be approved. Therefore, BWSSB package of water supply to the slum dwellers should be made available at affordable rates so that the spread of water-borne diseases can be eradicated.

3. Storm drains

Storm Drains network is an the backbone of the sewerage system in the Bangalore urban district. The primary storm drains extend over a length of 184 kms. in the city[6]. They guide water to all the major storm water valleys - Vrushabhavathi, Koramangala , Challaghatta, Hebbal I and Hebbal II. A substantial number of slums are situated on the fringes of storm drains. The conditions of these storm drains is an important factor in the day today lives of the slum dwellers. There are slums where the public water taps which are placed in the storm drains. For instance, in the case of ISRO slum, near the Cambridge layout, the slum dwellers collect drinking water, take bath which is at the silted area in the bottom of the storm water drains. Majority of slums which do not have access to UGD or sanitary lines within the slum, the drainage water flows directly into the storm drain.

(i). Health hazard

In Prakash nagar slum of Ward No. 23, Storm water drains, spanning the ward for about 3.9 kms. are full of filth, garbage and cow dung. The residents of Mariappanapalya slum adjancent Storm water drains suffer from diseases due to unhealthy environment. The storm drains runs near the Harishchandra crematorium, collects waste after funerals are conducted where they stagnate and rot.

In Ward No.26 (Sevashrama Ward) the children of Okalipuram slum, are down with fever due to clogged drain. Garbage adds to the clogged drain, flies and mosquitoes. The air is heavy with stench that breeds disease. Beside, the storm water drain in the area is surrounded by so much of garbage there is no place for drain water to flow.

In Ward No. 32 Dr. Devaiah, a house surgeon at Padma Devaiah Nursing Home in KP Agrahara says unhygienic conditions have brought in several diseases and slum dwellers are complaining of cholera, typhoid, skin diseases or viral infections. There is a urinal which is not maintained and is currently used as garbage bin. Many garbage bins are broken or overflowing.

(ii). Flooding of houses during rains

During rains, the dilapidated storm drains with stench and garbage spell misery to the slum dwellers. In Bangalore, the flow of water is from north to south. The woman of Gandhigram slum[7] are up in arms against the corporation authorities to close the eight feet wide sewage due to its unbearable stink. During rains the sewage mixes up with rain water and rushes into their houses. Out of the 300 houses, 250 of them have no sanitation facility.

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[6] Clogged Network by Aravind Gowda- Deccan Herald, 7 June 2002

[7] . Assessment by Training Research and Documentation Unit, KKNSS

In Ward No 63, adjacent to Chandrappa nagar slum, the huge drainage line looks like a garbage pit. Due to silt formation the sewage is clogged and the whole drain is now filled with garbage. For almost a year neither BCC pourakarmikars nor any one has cleaned this line. If the garbage is not cleared, the rains bring garbage to the streets and even to the houses. Adjacent to Mudalpalya slum, of Ward No 38, The Vrishabhavathi storm water drain is the source of an unholy stench. Most areas are low lying and susceptible to flooding during rains and subsequent overflowing storm water drains. Storm water drain, the collecting point of SWD water from all other wards on the way to the end of the Vrishabhavathi valley at Kengeri. It does not have retaining wall and has never been de-silted. Some rain and SWD overflows onto the residential areas

(iii). Flooding severe in the low lying areas

In the Ward No. 44, Faulty drainage and lack of de-silting in the storm water drains result in flooding of the low lying areas. Slums such as Rayapuram, Kamala Nehrunagar, JJR Nagar, Objlesh slum, Salappa line and Narasimhaiah compound are the most affected. Faulty drainage and lack of de-silting in storm water drains result in flooding of the low lying areas. The Goripalya slum has beef shops as added to the pollution of the storm drains.

From August 2002, the residents of Gandhi Gramam in the city, have been complaining of a stinking eight feet wide open sewage, that often floods their homes during the rains. The resident complain that the smell of the drain in the slum is so bad that during monsoons, when most houses are flooded the smell remains even after the water gets washed away.

One of the problem with storm water drains is blockage due to accumulation of garbage, waste, faulty drainage systems, and abject neglect by BCC in maintenance of the storm drains. Even after ambitious launch of the Swacha Bangalore programme, there is no door to door garbage collection system and waste bins in the slums and many middle class residential areas.

(iv). Blockages of storm drains by military and security establishments

The problem of storm drain has assumed gigantic proportions, due to termination of storm drains near the military and security establishments in Cantonment. The most affected due to storm drains are the slums in the Koramangala and Ejipura ward. The military authorities have terminated the storm drain disconnecting its flow towards Bellandur.

4. Absence of or improper UGD systems in the slums

(i).Internal

The slums of Bangalore city are the most polluted areas due to the absence or non-maintenance of UGD lines by the KSCB or the BMP. The sewerage systems within the slum has added misery to the slum dwellers. Lakshman Rau Nagar slum and Siddapura slum are the worst affected. The following are the factors is the contributor for the sewerage crisis in the slums.

(ii). Faulty design of UGD and sewerage drains

In Sambu Palya Slum of Ward No 48, the serious issue of the toilets is its faulty construction of UGD lines which passes though the narrow lanes of the slums. The frequent overflowing of the septic tanks in the UGD lines has caused severe hardship some families in the slum. The septic tanks are situated in front of houses, the overflowing excreta enter the houses. The faulty design and construction of the community toilet is the crux of the problem. UGD lines from the community toilet move upwards to connect the main UGD line. The lack of inspection by KSCB on the gradient level of UGD line has caused serious health hazards for the slum dwellers in shambu palya.

(iii) Non-maintenance of the drainage system

In Lingarajapuram Slum, The drainage system is a breeding ground for mosquitoes, the corporation authorities have not been maintaining these drains. The slum dwellers are forced to pay Rs. 15 per household for cleaning the clogged drains in the slums. Due to clogged drains, children in the area are always falling sick and slum dweller are forced meet the medical expenses as well.

In Nagina Palya slum, The state of drainage system is in a pitiable state. The poura karmikas come only once in 15 days and demand Rs. 2 from each household for cleaning the drainage. They dump all the waste in-front of the houses which is bad for the health of the slum dwellers. Slum dwellers have to bear the medical expenses when their sibling are affected with epidemics

In EWS quarters of Vinobanagar , each house has individual toilets with an open ended sanitary pipes.. As there is no septic tanks, human excreta flows through the open ended sanitary lines and drops behind the houses coupled with sewage water and garbage. This has caused huge environment crisis and diseases to the children.

Communicable diseases such as malaria, diarrhoea, acute respiratory diseases, tuberculosis are rampant in the slums due to lack of safe living environment in the slums

5. Non- Communicable Diseases

(i) Cancer

In Karnataka, about 45,000 cases of cancer are detected every year. The task force on health and family welfare says the prevalence of cancer is about

1.5 to 2.5 lakh cases in the state. Cancer is highest among the woman which is about one in twelve women. breast cancer, cervical cancer and uterus cancer are the most common incidences of cancer. Among these cervical cancer(21.5%) and breast cancer(18.6%) are the most common cancer sites among woman[8].

In the slums of bangalore city, the number of cancer patients who have been detected and undectected is increasing at phenomenal level. Majority of the slum woman are not even aware that they have been suffering from cancer.

(ii) Diabetes, Hypertension and CVD

Heart disease, high blood pressure, diabetes and obesity are much higher among the the city dwellers. 16% of the urbanites suffer from hypertension. The Cardio Vascular Disease(CVD) is now a major health problem with the bulk of it in developing countries. Ciggarette smoking and tobacco chewing all increase the risk of heart attacks as much as 300 percents.

One out of every 20 Bangaloreans may be a diabetic or on the way to becoming one[9]. Increasingly sedentary lifestyles, heavy smoking, alcoholism, poor food habits, obesity and the `thrifty gene' have resulted in, not only this garden city but the rest of urban India as well, to reel under a diabetes epidemic.

Various WHO reports point out that between 5-8 per cent of India's urban population (in some areas even above 10 per cent) are diabetics. In a city like Bangalore with a population of about 6 million, estimates are that between 2,50,000 to 3,00,000 are already diabetics. Another 1 lakh come from nearby areas. Many others have impaired glucose tolerance which could mean that they are within 4 to 5 years from actually becoming diabetics without lifestyle modification.

Due to high consumption rate of alcohol and tobacco, the rate of diabetes and CVDS are higher in the slums of bangalore city. Slums where Construction workers, loading and unloading workers, safai karmacharis and night soil workers are concentrated had known for high incidences of Diabetes and CVDs

6. Occupational Health

Atleast 50 - 70% of the workers in the unorganised sector residing in the slums are exposed to heavy physical workloads, leading to musculoskeletal disorders. Most affected in this category are construction workers, loading and unloading workers, Nightsoil workers, Municipal workers, woman involved in agarbathi rolling etc. Workers in the small scale industry are exposed to mineral, vegetable dusts like silica, asbestos and coal dust which are know to cause irreversible

[8] Study by Cancer Patients Aid Association, 2003
[9] Study by St Johns Medical College and McMaster University in Canada, 2002

lung diseases, TB, lung cancer and allergic reactions like asthama. The risk of cancer is high in the workplaces of small scale industry where 350 chemical substances have been identified as occupational carinogens, including benzene, hexavalent chromium, nitrosamines, asbestos,etc and ultra vilet and ionising radiations[10].

II. Health Care Infrastructure and Services

The Bangalore Mahanagara Palike(BMP) maintains about 30 maternity homes, 37 urban family welfare centres(UFWC), 25 dispensaries and 55 health centres. These public health infrastructure was built with financial assistance of the world bank under the Indian Population Project VIII. The health centres and UFWCs focus on health, nutrition education, entenatal/postnatal care, family planning, immunization mother & child, nutritional care of children up to the age of five. Apart from this, medical treatment of minor ailments and to act as referral units for the maternity homes was expected out of health centres and UFWCs. The maternity homes focus on delivery and medical termination of pregnancy(MTP) and laboratory tests. Maternity homes is also responsible for providing antenatal/postnatal care, family planning non-surgical care for children needing specialist attention and minor gynaecological procedures. The services of health centres, UFWCs and Maternity home is delivered for free.

The India Population Project - VIII

The India Population Project VIII (IPP VI) is a World Bank assisted project and has been in operation in the city from May 1994. The project aims at expansion of maternal and child health and family welfare services to the uncovered wards and population groups mostly the urban poor particularly the slum dwellers. The norm of IPP project is creation of one new health centre each for every 50,000 people. As planned, all the fifty five health centres have been created under the IPP VIII. The project also covers to improve the quality of health services being provided by the existing maternity homes of the BMP such as delivery, MTP and sterilization etc. for which health centres act as referral units.

The fifty five newly created health centres are presently under the administrative control of the IPP-VIII which supports the services of doctors, field staff and honorary link workers to the health centres. The Honorary link workers are volunteers residing in the slums, where they motivate mothers to utilize facilities

[10] Interview with Dr.Shashikala Manjunath, Occupational Health Specialist, Community Health Cell, ST Marathas Hospital, Bangalore, october 2002.

and services for ante-natal care, delivery family welfare, immunization. The BMP was able to build better health infrastructure with medical equipments,drugs and training for the technical personnel and public communication. IPP-VIII project was seen as project which improve quality of family welfare, maternal child care for the urban poor in the bangalore city

Corruption in the delivery of health care services

In 1999, the World Bank initiated process to ascertain whether the health care needs has been fulfilled and the impact of the IPP-VIII project on the health care system in bangalore city. The process took the form of consultation with different stakeholders/ beneficiaries in the selected slums of bangalore city. The findings underlines the fact that the health centres are assessed by the urban poor free of cost. In the case of maternity homes, maintained by BMP, none of its services such as sterlisation, MTP, delivery are available free of cost. The urban poor people were forced to pay bribes in majority of cases.

With the termination of World Bank Assistance in the year 2001, the IPP facilities has been integrated with the existing system of the BMP for routine operation and maintenance.

The surveys on maternity homes, UFWC and IPP Health Centres reveals that maternity homes are more popular among women for antenatal care than the other two providers. This indicates either a lack of awareness among the patients of the availability of these failcilties nearer their residences at the IPP Health centres or a reluctance to go to a new place. In either case there is a need to educate women on the advantages of using the IPP Health centre.

The level of corruption at Maternity homes is much higher than that of UFWCs and IPP Health Centres. One of the reasons for this could be that UFWCs and IPP Health Centres do not involve admission. The reason for which bribes are paid by most patients are for seeing the baby(69%) and for the delivery itself(48%). Other services like injections, family planning medicines, etc are also privided for payment of bribe but the extent is not so large. As far as the average amounts paid are concerned they are quite large for seein the baby and for delivery(Rs. 361 and Rs. 277 respectively) while other bribes are smaller in value.

Referral Role to Maternity homes by UFWCs and IPP Health Centres

Patients who had been to maternity homes were asked who referred them there. The response show that most of them came there on their own(68%), some were recommended by friends and relatives(8%) while 20% had been referred by IPP Health Centres and 4% by UFWCs.

Among patients who visited UFWCs and IPP Health Centres, 63% and 64% said they referred to maternity homes for delivery. Of these 81% and 67% went for their delivery to maternity homes from UFWC and IPP Health Centres respectively.

Health services to the poor women

BMP maternity homes is the only decentralised set of health facilities in bangalore that are accessed by relatively low income women and children. A network of outreach centres has now been created through IPP8 to expand and further strengthen the services of the maternity homes. While this expansion and upgradation of the health facilities for the poor needs is appreciated, it is important that careful thought is given to their proper utilisation, maintenance and effectiveness.

The following are the findings of the survey conducted in the year 2000[11]

- The overall satisfaction of patients was the lowest with the services of the maternity homes.
- Only a third rated them as good while 71% and 60% considered IPP centres and UFWC respectively as good.
- Only 39% of the patients of the maternity homes claimed that they received all medicines free as opposed to 63% in IPP centres and 61% in UFWCs. Maternity homes also lead in taking payments for injections. But the staff say that medicines are given free to all patients.
- Cleanliness of toilets is an indication of the standards of hygiene and sanitation. Here patients rated maternity homes the lowest (43%) in contrast to IPP centres (83%) and UFWCs(61%)
- Maternity homes were rated the lowest also in terms of staff behaviour towards patients. But the gap between them and IPP was much smaller in this case.
- The most distressing finding concerns the prevalence of corruption. About 90% of the respondents reported paying bribes for one service or other at maternity homes at an average of Rs. 700 each. The 70% pay for seeing their own babies. One out of two pay for delivery.

If a poor woman paid for all services, it would have cost her over Rs. 1000 for a delivery. It is reported that a nursing home might give her hassle free and better quality service for Rs. 2000. A rough estimate of the bribes being paid in all these

[11] User Feedback Survey by Public Affairs Centre in colloboration with Sumangali Sevashram, REDS, MAYA, Citizens Action Group and Community Health Cell

facilities may be between Rs. One and two crores annually. A similar estimate based on the finding that 90% of the women pay about Rs. 700 at the maternity homes would put the total amount of bribes paid at about Rs. 1.6 crores. The annual emoluments of the staff at the 30 maternity homes also amount to about Rs 2 crores.

Report on Health of the urban poor held on Peoples Health Day – 7th April 2003
At Ashirwad Bangalore, facilitated by Community Health Cell and KKNSS

Report by : S.J.Chander

Background

World Health Organization (WHO) having recognized that the health services expected by the people was not being provided, in 1997 during the World Health Assembly called for a revolutionary approach In Health Care that would enable the citizens attain a level of health that will permit them to lead a socially and economically productive life. In 1978 in the conference held in Alma Ata, Russia, Health For All by 2000 AD was declared. Primary Health Care approach evolved based on the experiences of countries like Sri Lanka and India was suggested as the best way to attain the goal. Services based on PHC approach were developed over the years for the rural poor but to far the urban poor the services available were family welfare and family planning.

He said the PHC approach though initially experienced some gains, gradually moved from comprehensive health care to more a selective primary health care approach. Pulse polio programme can be given as an example. National Health Policy 2002 draft is out and it is evident in it the shift. Process of globalization and influences of various lobbies are some of the factors that have had negative effect on people health. Of late the trend is moving more towards privatization.

This year is the silver jubilee of the Alma Ata declaration, it appears that WHO and the governments have forgotten the goal Health For All (HFA) by 2000 AD. Jan Swasthya Abhiyan (JSA) in India, known as People's Health movement internationally believes that it is the comprehensive health care that is going to help people attain the level that was envisaged by WHO during the declaration. It is time that both the government and the people's organization work together to achieve Health for All now!

Dr. Mala Ramachandran, Director, Urban Health Training and Research Center, Bangalore who was invited to share on the health services available for the urban poor said, approximately there are 15 lakhs people live in the slums of Bangalore. Population growth is the cause of the state of affairs in the slums. Usage of MCH services and Immunization coverage is low. Problems like cancer, diabetes, hypertension is prevalent. HIV AIDS and Tuberculosis are the other problems of concern to the urban poor. Safe drinking water and sanitation continue to be inadequate. During the response to Dr. Mala's presentation, the participants said, despite the efforts to control corruption. It is still rampant. There was concern among the participant regarding the removal of Link Workers who were working at slum level.

Followed by Dr. Mala's presentation, Mrs. Ruth Manoramma of Women's Voice shared urban poor do not have policy to address their needs. She said national policy of urban poor is being developed. The present family welfare programmes exclude men from the service coverage. Regarding sanitation needs, she said 70% of the Indian population still

does not have toilets. Women are the ones who are affected more due to lack of toilet facilities. From the 9th five-year plan it was observed the budget for health being decreased and budget for social welfare continued to face cut. The critiques have said the following: Public sector is moving towards privatization, public sector budget faced cut, commodification of health care, population gets major focus and distortion of priorities. Regarding her suggestions to change the scenario, she said the following:

1. We should demand for comprehensive primary
2. Introduction of barefoot doctors cadre and youth for prevention HIV/AIDS
3. Recognize urban health as an important component in Health Care services
4. Obtain information regarding health care services and disseminate widely among people
5. People should demand for transparency and accountability with the govt. services.
6. There is need to understand socio cultural and economic dimension of the causes of the illnesses.

Followed by Mrs. Ruth's presentation Ms. Preetham of Janagraha shared about their work in developing indicators for the health services. She said at present Jangraha is involved in the following three campaigns: a. ward work campaign, b. Proof campaign, and 3. Ankoor, which focuses on the services of SJSRY. They approach they have adopted is budget analysis, in which they analyze the budget allocated, actually spent and the quality of service. As an example she gave the education budget of the MBP when worked out the equation, the total cost per child per year works out to Rs. 29,000. She said the output for such a high investment is unacceptable. She said without information based on evidence objective discussion is not possible with the service providers and performance indicators help us demand accountability. At present she said they are experimenting with the approach: collect information, analyze, and organize management dialogue for improvement with education and heath care sectors of BMP.

Mr. Madhusudhan of KKNSS concluded the meeting with vote of thanks. It was decided at the end of the meeting to form a forum consisting of voluntary organization working with the urban poor for identifying and addressing the issues of concerns to urban poor under Janaarogya Andolana.

JANAAROGYA ANDOLANA - KARNATAKA

Action Plan for Intervention for Bangalore City for the year 2003-04

- (For Discussion Only)

Goal

To enable a better healthy environment and access to health services for the urban poor in bangalore city

Objectives

- To build capacity of the Organisations/CBOs to equip them to address the health issues in the BMP area
- To Facilitate better accessibility of urban poor's Access to Health services provided by the BMP
- To mobilize ~~the~~ all stakeholders concerning health to directly address the burning health issues in various locations of Bangalore city

Output

- Training programmes regarding health on Infant Health, Nutrition, Adolescents , reproductive health. communicable diseases(AIDS, Cholera, Typhoid, Malaria), non-communicable diseases(Diabetes, Cancer, Hypertension), occupational health (Construction, Municipal Workers, Domestic Workers) and Substance Abuse(Alochol, Tobacco)
- Health Camps or disease detection camps at various locations of bangalore city
- Evolving mechanism for monthly interaction between the users and providers of BMP
- Direct Action on Explosive health hazards at various locations of the city which affects the slum dwellers.

Indicator

- Training programme on 2 health topics every month
- 2 detection camps for detecting the scale of cancer and diabetes among slum dwellers
- Health Adalat - Complaints, grievances of urban poor presented before the doctors & staff of the health centres. Conducted at each health centres level for every month
- Improving environment at EWS quarters, slums adjancent to Storm drains, Slaughter houses, and building health infrastructure

Activities

SL No.	Activity	Process Indicator	Product Indicator
1	Capacity building	50 Health workers, field workers and CBOs will be trained. Resource material will be distributed and evolving action plan	Infant Health Nutrition Immunisation Communicable diseases Non-Communicable disease Adolescent health Reproductive health Occupational Health Substance Abuse
2	Health/Disease Detection Camps	3 Health detection camps for organising detection of high concentration of diseases such as tuberculosis, cancer and diabetes	Document on Findings of the detection camp Strategy document on curative and preventive measures to contain the diseases
3	Monthly Interaction between slum dwellers and service providers of BMP's Health Infrastructure	12 monthly interaction at 55 IPP centres per month. The doctors, staff, CBOs, slum dwellers interact to improve the services of health infrastructure	Health Adalat - a mechanism to for exchanges between users and providers of BMP's health system.

4	Direct Action to pre-empt an explosive unhealthy situation	Organising inspections from the government agencies. Media splash Enabling systems within government to prevent such situations	Building up an health environment in slums adjancent to Storm drains Improving the environment in Vinobanagar, Shambupalya slum etc., Improving the environment within the slaughter houses on tannery road and protection of slum dwellers who work there.

what is PROOF?

Performance audits and quarterly financial statements are universally acknowledged as essential mechanisms and criteria of and for progress. The Corporate sector, the NGO world, CBOs and civil society have not only embraced the concept , but used it as the basis of performance measurment and the springboard of good governance . Today, we need the Government to practice it, PROOF provides this platform. It is about our Government building confidence with PROOF.

building confidence in government

If accountability and transparency have become critical benchmarks for governance in India today , PROOF is a rigorous and systematic vehicle, to root both in terra firma. The Public Report of Operations and Finance (PROOF) provides a synergistic opportunity for government and citizenry to join hands and demonstrate that public money is being used for public good.

Lack of transparency in performance reporting from government institutions is a worldwide affliction. On the other side of the coin, there have been a variety of initiatives across the world which have harnessed their energies in building mechanisms to promote regular and standardised reporting from government institutions. Punching home the point is the observation of the Governmental Accounting Standards Board (GASB), which asserts that "Accounting and financial reporting standards are essential for the efficient and effective functioning of our democratic system of government". PROOF will translate this premise into reality.

what is PROOF

A 10 month campaign which kicked off on July 3rd 2002, it's mechanisms will put in place a systematic structure of government performance reporting along the lines of the private sector . This could become the centrepiece of improved government performance and incrementally be substantiated with additional performance indicators and explanatory statements .

"I support the PROOF campaign wholeheartedly. As CEO, I cannot imagine running my organization without credible information being produced, disseminated and used on a regular basis by all stakeholders: investors, management, employees, board members as well as the financial markets. Especially in today's climate, such information is more than just about performance, it is about fundamental institutional integrity.

This is in fact one of the reasons why the BATF has invested enormous resources and 200,000 manhours over the past 30 months in supporting the BMP to put together a world-class financial management system called FBAS. Ultimately, the payoff is in the social realm, where citizens see the benefits.

With the Chief Minister's vision, as well as the commitment and dedication of the Mayor and Commissioner, the BMP has an unprecedented window of opportunity to fundamentally transform itself. Such an alignment of political will, public-private partnership and professional competence is very rare.

PROOF can be a big part of this transformation."

Nandan Nilekani
CEO, Infosys

what is PROOF?

what is in PROOF

While the contents of the Proof document will gradually become more standardised, a framework of performance information will be gathered in three crucial areas:

1.Financial Statements of the institution for the period under scrutiny comprising :
   a) Revenue and Expenditure Statement compared to original Budget figures
   b) Indicative Balance Sheet , with detailed information about current and long terms assets in addition to short and long term liabilities.

2. Performance Indicators :
   a) Inputs
   b) Outputs
   c) Efficiency indicators
   d) Explanatory notes

3. Management Discussion and Analysis
   a) Overall performance
   b) Discussion of selected activities

"Information sharing through disclosure has become the NORM, and more so financial disclosures. When corporate and other bodies are expected to publish their financial results quarterly, there is no reason why government bodies which deal with revenue collected from the public should not publish their financial status quarterly.

The PROOF compaign is trying to awaken everyone, and taken to the logical end, this would bring results to all stakeholders. I fully endorse the campaign."

R Thotadri
Managing Director (Retd.)
LIC of India

the PROOF campaign

"Starting with the quarter ending June 30th 2002, the campaign is about the BMP building confidence with quarterly statements of PROOF: full and accurate performance information to the city's various stakeholders".

Consequently there will be four quarterly review opportunities. These will take the shape of public debates and discussions, the first of which will be held in early August 2002.

Each review by itself will serve as an opportunity to bring financial accountability and performance into the public space. However, these reviews are also catalysts in a larger process of bringing government and public closer together. In practical terms, each review will act as a bench mark and provide the basis to develop, reshape and accelerate other mechanisms of analysis and participation.

what is PROOF?

campaign partners

In order to actualise this process and operationalise the vision , four partners with different skill sets have subsumed their identities under the PROOF umbrella. They are :

NAME	RATIONALE
1. CENTER FOR BUDGET AND POLICY STUDIES	Performance Analysis
2. PUBLIC AFFAIRS CENTRE	Transparency through Report Cards
3. VOICES	Community Awareness & Communication
4. JANAAGRAHA	Citizen Mobilization & Participation

"PROOF as a campaign for fiscal performance audit by the public is truly commendable. This will greatly help to promote transparency, accountability and efficiency in public decisions."

Dr. M Govind Rao
Director
Institute for Social and Economic Change

conclusion

Disclosure, debate, dialogue and discussion between Citizen and Government characterises both the spirit and process of PROOF. This is an opportunity for the BMP to build confidence with its various stakeholders in a manner that is open, sustainable and constantly deepening.

Your participation will both accelerate and enable PROOF to translate its promise to performance .

For more information, contact us at :
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Fax: 354 2966
proof@vsnl.net

format of PROOF

format of financial statements

REVENUE STATEMENT					
Major head of account	Budget 2002-03	Actuals (2002-03) Q1	%Achieved	Comments on Performance	Queries
A. Revenue receipts					
A1. BMP Own sources					R1
a. Property Tax					R1
b. Other taxes					R1
c. Non tax revenues					R1
Fees – Building license fees					
Fees – Road Cutting charges					
Rents from shops and markets					
A2. Government sources					R1
a. Shared taxes with GoK					
b. Finance Commission grants from GoK					
c. Other specific grants					
Total Revenue Receipts (A1+A2)					
B. Capital Receipts					
B1. BMP Own sources					
a. Improvement charges					R1, R2
b. Sale of assets (Land, markets etc)					R1, R2
c. Other					
B2. Government sources					R1, R2
a. MOU/ Rajdhani fund					
b. Other specific grants					
B3. Borrowings					R1, R2
a. From Government					
b. From HUDCO					
c. From KUIDFC					
d. From other sources					
Total Capital Receipts					
C. Fiduciary Receipts					
C1. Deposits					R1
C2. Cesses					R1
C3. Taxes					R1
C4. Other fiduciary sources					R1
Total Fiduciary Receipts					
GRAND TOTAL OF RECEIPTS					

R1 – Which are the key items of receipts; how did they fare versus your budget plan; where did we do better, where did we do worse; what specific ideas are you adopting to change this in the next 3/6/9 months before the year ends?

R2 – If we are getting funds from capital receipts like sale of assets or improvement charges etc; do we spend these funds on capital expenditures? As an example, how do we ensure that improvement charges get spent on the areas from which the funds were collected?

"The taxpayers of Bangalore city who sustain the BMP expect not only better results on the ground, but also regular reports on performance. PROOF is the answer to this, and I am hopeful that the BMP will be self-motivated to provide PROOF. I am glad to learn that this campaign is actively involved in creating that motivation.".

C G Somiah
Former Comptroller and Auditor General of India, Govt of India
Former Chairman of the United Nations Board of Audit

format of PROOF

EXPENDITURE STATEMENT				
Major head of acount	Budget 2002-03	Actuals (2002-03) Q1	Comments on Performance	Queries
A. Revenue expenditure				
A1. Salaries and Allowances				E1
A2. Pension				E1
A3. Interest on borrowings				E1, E2
A4. Maintenance & Repairs				E1
a. Buildings				
b. Vehicles				
c. Engineering (roads/ drains maintenance etc.)				E3
d. Others				
A5. Other Revenue Expenditure				E1
TOTAL REVENUE EXPENDITURE				
B. CAPITAL EXPENDITURE				
B1. Buildings				E1, E4
B2. Furniture and Fixtures				E1, E4
B3. Machinery and Equipment				E1. E4
B4. Ward Works (roads/ drains construction etc.)				E1, E3
B5. Comprehensive Development of the city				E1, E4
B6. Slum Development				E1, E5
B7. Solid Waste Management				E1, E4
B8. Commercial Complexes				E1, E4
B9. Princial repayment of borrowings				E1, E2
B10. Other Capital Expenditure				E1
TOTAL CAPITAL EXPENDITURE				
C. FIDUCIARY EXPENDITURE				
C1. Deposits				E1
C2. Cesses				E1
C3. Taxes				E1
C4. Other Fiduciary Expenditure				E1
TOTAL FIDUCIARY EXPENDITURE				E1
GRAND TOTAL OF EXPENDITURE				

E1 – Which are the key items of expenditure; how did they fare versus your budget plan; where did we do better, where did we do worse; what specific ideas are you adopting to change this in the next 3/6/9 months before the year ends?

E2 – We had taken out the Municipal Bonds a few years ago. Can you give us some details about the status of these bonds, and the usage of funds: what was the original usage, versus actual usage?

E3 – What is the total expenditure incurred on Storm Water Drains? How much of this is capital expenditure, and how much was spent on maintenance and desilting?

E4 – Please provide some details on major capital expenditures being incurred this year. How much has been spent, and what are the additional expenditures in these areas for the remainder of the financial year?

E5 – In the area of Slum Development, what kinds of activities have been taken up? What is the proposed expenditure for the rest of the year?

"PROOF is a step towards making people know how their money is being spent. And therefore, it is welcome."

Chiranjiv Singh
Principal Sceretary, Finance
Government of Karnataka

format of PROOF

STATEMENT OF ASSETS					
List of Major Assets	As on 30/06/2002		For Q1		Queries
	Number	Value	Income	Expenditure	
A. Fixed Assets					
a. Land					A1, A2
b. Land (leased out)					A1, A2, A3
c. Buildings used by BMP					A1
d. Buildings – Commercial					A1, A3
e. Infrastructure assets					
f. Other fixed assets (furniture, machinery etc.)					
B. Investments					
C. Current Assets					
a. Receivables					
property / other taxes					
other receivables					
b. Advances					
to contractors					
to employees					
c. Cash and bank balances					

A1 – We know that the BMP owns several properties in the city. Can you give us a list of these properties? Have you valued these? How are you managing these assets, so that they stay valuable for the BMP?

A2 – Are you planning to convert any of these properties into revenue opportunities for the BMP? If so, how will you do this: by selling the property outright, or doing a joint-venture? How do you make these decisions so that the BMP gets the best value? How will you ensure that there is transparency in these decisions? What will you do in the next 3/6/9 months?

A3 – What are the commercial activities of the BMP?

- What is the total value of all BMP's commercial properties?
- How much money are we spending on building new commercial properties?
- How much money are we spending on maintaining existing properties?
- Since these are commercial properties, are we making a profit on managing these assets? If so, what are we doing with the profits? If not, why not; what are you doing to convert these into profitable propositions in the next 3/6/9 months?
- As one example, we understand that the Public Utility Building is a BMP asset; what rent do we get from this building? what are our expenditures for this building?
- Why is the BMP undertaking commercial activities? Is there surplus money in the institution? Is this an obligatory activity of the BMP? Will we continue to undertake commercial activities in the future?

A4 – What is the total area and number of pieces of land that BMP has leased out? What are the purposes for which these lands are leased? How are these decisions made? Are these optimal decisions? If so, how do you say so? If not, how will these decisions be rectified and what specific action is being planned over the next 3/6/9 months?

"I endorse the PROOF campaign. As an NGO, Myrada tries its best to fulfill its Mission with passion and professionalism; the latter demands respect for adequate and acceptable organizational and financial management systems and indicators of performance. Without professionalism, passion only makes news, and is often counter-productive."

Aloysius Fernandez
Executive Director
Myrada

format of PROOF

STATEMENT OF LIABILITIES			
List of Major Liabilities	As on 30.06.2002	Dues Q1	Queries
1. Specific Grants			
a. From Govt of India			L1
b. From State Government			L1
c. From others			L1
2. Loans			L3
a. Government			L1, L2
b. HUDCO			L1, L2
c. KUIDFC			L1, L2
d. Others			L1
3. Current Liabilities			
a. Dues to Contractors			
b. Dues to Suppliers			
c. Other liabilities			
d. Cesses & Taxes to Govt			

CASH BALANCE	
Opening Balance as on 1st April 2002	
+ (Total Receipts during Q1, 2002-03)	
- (Total Expenditures during Q1, 2002-03)	
Closing Balance as on 30th June 2002	

L1 – How many years are left for repayment of the various loans or grants, either to Government or to HUDCO, KUIDFC etc?

L2 – How does the BMP decide on loan financing of projects? Since these loans have interest payments, do the assets being created have to generate cash flows to pay back for the loans, or do these repayments come from other sources?

L3 – Is the BMP considering raising more debt in the next 3/6/9months. If so, what are these loans for, what are the details of such loans (interest rate, duration etc.), and how is the BMP intending to pay back the loans?

"We support the PROOF campaign. As our contrbution to the campaign's success, we are happy to organize a seminar at our premises to help the Corporators and Department officials of the BMP read and understand financial and other disclosure statements needed for fostering greater transprency and accountability."

K S Madhava Murthy
Chairman
Bangalore Branch of SIRC
The Institute of Chartered Accountants of India

Vinay Bruthyunjaya
Regional Council Member
Bangalore Branch of SIRC
The Institute of Chartered Accountants of India

format of PROOF

developing performance indicators

Specific Performance Indicators (PI) are not yet developed. Although such performance measures are required, they need to be developed over time, in areas of concern to the citizens as well as the Management of the BMP. The items mentioned below are broad questions related to performance measurement, intended to begin the process of identifying topics and areas of interest.

PI-1: EDUCATION

- How much money is spent on the education department?
- How many students do we have in corporation schools; how many schools do we have?
- Is the cost per student that we spend every year reasonable for the quality of education that is provided?
- If so, how do you determine this; if not, what are you going to do about it?
- Which are your best-performing and worst-performing schools?
- What kinds of performance measures do you think are appropriate for this department?

PI-2: HEALTH

- How many dispensaries and hospitals do we have?
- How much money is spent on the hospitals and dispensaries that we have?
- How many in-patients and outpatients does the BMP treat?
- Is there any measure of cost/outpatient, or cost/inpatient/day that has been evolved?
- What kinds of performance measures do you think are appropriate for this department?
- Which are your best-and worst-performing dispensaries and hospitals?

PI-3: HORTICULTURE

- How many nurseries does the BMP own?
- How much land does this occupy?
- Is horticulture considered to be a revenue-generating activity for the BMP, or an obligatory function?
- How much revenue does this department generate?
- Is this sufficient for the land that it possesses; if so, why do you state this; if not, what are the plans over the next 3/6/9 months?
- What kinds of performance measures do you think are appropriate for this department?

PI-4: ENGINEERING

- How many works (number and total value) are currently under way in the Engineering department, and which years do these works belong to?
- How many works (number and total value) will spillover into next year, and what are the causes for such spillover works?
- How many of these works are maintenance in nature, and how many would you classify as long-term capital expenditure?
- What kinds of performance measures do you think are appropriate for this department Management Discussion and Analysis?

format of PROOF

management discussion and analysis

This section is left open for Management to provide additional qualitative information on various aspects of their choice. As an example, these items could relate to:

- Management Priorities for the first 3 months, and for the next 3/6/9 months in this financial year
- Key challenges that arose during the past 3 months, and issues related to these challenges
- Human Resource Development discussion
- Any other strategic or operating items

frequently asked questions

1. With all the problems being faced by the corporate sector (like Enron etc.), how can these disclosure norms be considered "Best Practices"?

   Disclosure by itself is not a sufficient condition for good governance, either in government institutions or in the private sector. However, the disclosure of accurate and timely information is a necessary condition for good governance. Without disclosure, there cannot be good governance. The problems of the private sector only show that better quality information needs to be disclosed, and that all stakeholders must examine such information more carefully.

2. Why do we need PROOF when there is already the Budget?

   The Budget serves the purpose of a planning instrument, which is very important. We also need stakeholders to engage on issues of performance, over the course of the year

3. Will this not put additional pressure on the BMP to generate all this information?

   The financial data in PROOF is being asked for in a standard format. The BMP Management is probably already using such information to run the organisation efficiently. Emerging global standards of government financial disclosure are also in line with PROOF

   The BMP and BATF have invested over 200,000 manhours in building a world-class financial management system, so generating this information should not pose much difficulty

4. What are the legal requirements for the dissemination of such information?

   - Karnataka Municipal Corporations Act (KMC Act), Schedule III -1(3): "The account books of the Corporation shall be open without charge to inspection by any person who pays tax to the Corporation or his authorised agent on any day or days in each month to be fixed by the Corporation"
   - KMC Act, Schedule I -Rule 4: "At an ordinary meeting held in each of the months of April, June, August, October, December and February, the Mayor shall place before the corporation a statement of receipts and disbursements on account of the Corporation fund from the close of the last preceding year up to the close of the month before that in which the meeting takes place."
   - KMC Act, Section 61-A-(e): " The Standing Committee for Accounts shall deal with all matters relating to Accounts and Audit."
   - KMC Act, Section 61-A-3(a)(b): "The Standing Committee..may conduct a monthly audit of the Corporation accounts and shall be bound to check the monthly abstract of receipts and disbursements for the preceding month as furnished by the Commissioner."
   - KMC Act, 9(2)-Part II- Schedule IX: "The Commissioner shall make ready the annual accounts and registers and produce them before the auditor for scrutiny not later than the first day of October in the year succeeding that to which such accounts and registers relate."
   - KMC Act, 12-Part-Schedule IX: "The auditor shall submit to the standing committee for taxation and finance a final statement of the audit and duplicate thereof to the government within a period of three months from the end of the financial year or within such period as the government may notify."
   - These are some of the provisions. There are other provisions dealing with the powers of the Standing Committee for Taxation and Finance, as well as those of the Chief Auditor

5. How will the Performance Indicators be created?

These indicators have to be evolved over a period of time, with discussion between the BMP and various stakeholders so that the appropriate Performance Indicators are created, for example, for roadworks, SWM.

The list of questions currently being asked in the section on Performance Indicators only begin the process of public participation in the area of performance measurement.

6. How can the public participate in the information that is disseminated through the PROOF documents?

There will be a public debate held every quarter. These public debates will be around the PROOF information that is disseminated by the BMP. These debates are specifically meant to trigger larger public discussion about the key issues arising out of the quarterly performance of the BMP.

7. Once the BMP releases PROOF, how can the average citizen understand the documents?

The PROOF format itself is quite simple to understand. The financial statements are extremely simple and straightforward, and presented in a standardised format.

The benefit of using standardised disclosure formats is that there are many who know how to interpret them: Chartered Accountants, financial analysts, NGOs, students etc.

These skills are already in the communities, and can be used to have grassroot discussion sessions about PROOF.

Training programmes to understand PROOF will be held, to create a greater awareness of such documents. In addition to the 4 partners of the campaign, the Institute of Chartered Accountants has offered to conduct such training programmes for interested persons.

8. How frequently will the PROOF documents be released, and how frequently will the public debates be held?

The Campaign for PROOF is to obtain these documents on a quarterly basis. The Public Debates will also be held every quarter.

The first public debate will be held around the 15th of August, for the discussion of the First Quarter's performance of the BMP in the financial year 2002-03.

Subsequent Public Debates will be announced in advance, to ensure maximum participation from the various stakeholders in the city.

partner endorsements

CBPS

Centre for Budget and Policy Studies

Dr. Vinod Vyasulu
Director

The Centre for Budget and Policy Studies, Bangalore was established in 1998 by a group of professionals based in different institutions. The mission of the Centre is to contribute through research to contemporary debates around issues of poverty, employment, environment, gender etc. The Centre believes that both economic growth and equity are essential for all round development, and that it is also essential to work at the local levels. Therefore, in its work, the Centre has begun with an analysis of budgets. A budget is a promise made by an elected government to the people who have given it its mandate. Has the government a followed policies in line with its promises? Has money allocated been spent? If not, why not? Has the money required been raised by equitable or regressive tax policies? These are all matters that impact on the daily lives of ordinary people. Budgets tend to be long and technical documents. It often needs economists and accountants to act as intermediaries to make the numbers understandable to the ordinary citizen. This is a task CBPS has taken on.

CBPS is privilege to work with its distinguished partners in the PROOF campaign. The Public Affairs Centre is well known for its work, including the innovative Report Cards on citizen satisfaction with civic services. Voices is a well known organisation concerned with democratising the media and both reaching, and giving voice to, the views of the poor. Janaagraha has just completed a campaign in which citizens were encouraged and enables to interact with their elected corporators in a joint endeavour to include locally important works into the ward works to be taken up by the city corporation. Together, we can make the Proof campaign a worthy successor of what each has already accomplished-- and take the exercise to a higher level.

Proof is about building confidence. The BMP offers a Public Report Of Operations and Finances on a quarterly basis over the next four quarters which will enable citizens to to understand how things are working. How are projects taken up? How well are taxes being collected? What problems does the BMP face, and what can citizens do to help? The potential is great.

If all of us are to contribute to a better Bangalore, we all have to take some responsibility for how our city develops. The BMP is the prime agency to lead this task, but without our help it may not be able to achieve all it should. The Proof campaign is a small beginning to make things better by working together.

4/7/2002

1C, S.V. Complex, 1st Floor, 55 K.R.Road, Basavangudi, Bangalore- 560004. India
Phone: + + 91-80-6522327 Fax : + +91-80-6618401 email:cbps@vsnl.com

JANAAGRAHA

Janaagraha | Team up for a Better Bangalore

PROOF and Janaagraha

When Janaagraha was launched last December, it was with the singular focus of bringing the voice of the citizen into the decision-making process of government.

Our first campaign of ward works budgeting has completed its first phase, and is continuing into the second phase of participation in implementation of these works.

We believe that PROOF is a remarkable opportunity to create a platform for citizen engagement. Information that comes out of the PROOF documents will only be the first step. By itself, this information is passive, inert. It needs to come alive with participation, internalisation and ownership by the citizens in their neighbourhoods.

Our vision for how this will work is that the PROOF documents act as a catalyst for the average citizen to engage more, get a firmer comprehension of how - in this case - their local BMP government works, and then take the next step: ask the question, "What does this mean in my ward, my locality?" This will in turn spur more disaggregated analysis and debate.

Another important aspect of PROOF are the Performance Indicators: financial data is a necessary condition to understand an institution. It is not a sufficient condition, however. This financial data needs to be supplemented by performance data. How well is the BMP doing in delivering primary education services to the children in corporation schools? How efficiently are the hospitals and dispensaries running? These are important questions, but require careful deliberation before the right parameters of performance can be evolved.
Our view in Janaagraha is that these perfonnance indicators cannot be developed in a vacuum; they need to evolve t hrough debate and discussion. Let the people participate in determining which areas need to be prioritised in the development of performance indicators - after all there are hundreds of potential metrics. Then let there be discussion on what these performance indicators ought to be. These could take several iterations, but the body of knowledge will only grow, and the spaces for engagement will only become more robust.

In summary therefore, Janaagraha is a partner to the PROOF campaign because we believe that this marks a radical departure to the mindset of the past: with regular, standardised information, public engagement can become a reality in tangible terms. Of course, there will be many obstacles. That is part of change. All we can ask for is to be, in the words of Richard Hofstader, "a thorn in the side of complacency."

Ramesh Ramanathan
Campaign Coordinator

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Phone: 080 - 354 2381, 354 2382, 333 0668
email: janaagraha@vsnl.net

partner endorsements

PUBLIC AFFAIRS CENTRE

578, 16th B Main, 3rd Cross, 3rd Block
Koramangala, Bangalore 560 034, India.
Tel / Fax : (080) 5537260/3467, 5520246/5452/53
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PROOF: A Campaign for Tranaparent Governance

The Public Affairs Centre's mission, to improve the quality of governance in India by strengthening civil society, draws heavily on the power of informed choice and action by citizens. Its work on Citizen Report Cards, campaigns for electoral transparency, promoting Self-Assessment of Property Taxes, and demystifying municipal budgets are a testament to its commitment to make information a basis of informed action. "PROOF" is a continuation of this effort. It offers PAC the platform to tie together all the different elements of its work in Bangalore, and be a partner in an effort that builds on the commitment of citizens and institutions in Bangalore, to make a different where it matters most.

PROOF is a lot more than another advocacy campaign for PAC. It is an opportunity to work with four dimensions of citizen - state interaction (**Four D's**) that are vital to good governance, namely:

- Meaningful and sustained "**disclosure**" of information that empowers elected representatives and citizens
- Providing a plaffomm for meaningful "**dialogue**" among stakeholders
- Facilitating active citizenship that can "**debate**" local issues
- Setting agendas based on long term "**direction**" beyond short term issues.

This first PROOF campaign, for 10 months, is a period for deliberate reflection and systematic action by PAC and its partners. For the Centre, it is a reiteration of it's commitment to pursue the goal of facilitating informed action by citizens while interacting with the state, and has a meaning beyond the immediate results to be achieved in 10 months.

This campaign is not a stand-alone effort. It builds on the upsurge in civic consciousness and citizen action as well as the tremendous effort made by the BMP to reach out to residents of Bangalore. Hence, it is an effort that draws in citizens, civil society institutions and city government of Bangalore to expand the scope for active participation and partnership, on a continuing basis.

PROOF is also about the spirit of Bangalore, its citizens and city government. Which is why the city is home to some of the best-known recent initiatives in participatory urban governance. To PAC, this campaign is an opportunity to consolidate the pioneering work by its citizens and institutions, and hold out a model that others, from all parts of the world, can learn from Bangalore.

July 4, 2002

Samuel Paul
Chairman

VOICES
a unit of Madhyam Communications

165, First Floor 9th Cross, 1st Stage,
Indranagar, Bangalore - 560 038.
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www.voicesforall.org

July 4th 2002

Access has been universally acknowledged as a critical ingredient for change and participation . As an organisation committed to democratisation of the media, VOICES has directed its efforts towards developing and strengthening community media mechanisms that not only inform but also accelerate the pace of community participation in governance . These mechanisms, as amply demostrated by the first campaign of Janaagraha, confirm that community communications are critical catalysts for dialogue, discussion and debate . VOICES efforts with poor farmer groups in Budhikote village, Kolar, in partnership with MYRADA is another example of community engagement in local media. It is also part of a larger process of advocacy and lobbying underscoring the need for community radio in a country that remains to straddle the literacy gap.

The MKSS and Aruna Roy's efforts in Rajasthan have endorsed exactly why the Right to Information in not just about rights, but also about responsibilities . If community participation is at the bedrock of its effort, community communications have been a vital enabling agent which has taken the process forward . The Jan Sunwais (Public Hearings) employed by MKSS is a case in point .

P.R.O.O.F. comes at a point when transparency and accountability have assumed crucial significance in governance . The news today which describes the doublespeak about the roads at K.R. Puram underlines its relevance . By using quarterly financial statements as its peg P.R.O.O.F. articulates universally accepted benchmarks for progress . It provides a powerful opportunity for government and citizenry to join hands and colletively strengthen governance . Along with the other partners, VOICES will work through a range of media, to disseminate relevant information and strive to ensure that community voices take primacy . This process will affirm that P.R.O.O.F is not only a matter of questions, but also a question of answers.

Ashish Sen

Ashish Sen
Director
VOICES

PERFORMANCE INDICATORS FOR HEALTH

INPUT	OUTPUT	OUTCOME	EFFICIENCY	PRODUCTIVITY	EXPLANATORY
• Minimum Infrastructure Standard General Ward Labor Ward Operation Theatre (OT) Minor Operation Theatre Toilets Condition of toilet Bathrooms: -- Availability of hot water -- Availability of sewage system. Laboratory Waiting Area Patient Attendant Space Outpatient Area Availability of drinking water Linen Service Generator set Store Room Ambulance Service Quarters for Doctors and Drivers Telephone Service Privacy of examination area Fumigation • Minimum Equipment Standard. Availability of required Equipment in all rooms. • Drugs Availability of minimum essential drugs. Availability of emergency drugs.	• Number of deliveries Normal Caesarean and Assisted • Number of family welfare procedures. • Number of high risk pregnancies detected during labor / antenatal care • Number of immunizations against measles. • Number of admissions. • Number of admission slips. • Number of patients registered for postnatal care. • Number of patients registered for antenatal care. • Number of Medically Terminated Pregnancies (MTP).	• Number of maternal deaths. • Number of neo natal deaths. • Number of stillbirths. • Number of infant deaths. • Number of perinatal deaths. • Number of measles cases. • Number of deaths due to measles • Number of admission to number of admission slips. • Complaint redressal system. • Patient feedback forms. • Percentage of patients coming in for 3 postnatal check ups. • Number of patients registered for antenatal care prior to 12 weeks. • Number of days with stock outs of essential drugs.	• Downtime of key equipment. Autoclave. Laproscope. Refrigerator. Generator. Ambulance BP Apparatus Instrument Sterilisers Weighing Machine – Adult and Infant Incubators Boyle's Apparatus Pulse Oxinator Hysteroscopes • Time taken to fill up vacancies to sanctioned strength. • Nurse patient ratio. • Doctor patient ratio. • Full time employees per occupied bed. • Waiting time for patient. • Cost of drugs per patient (inpatient / outpatient). • Cost per inpatient day. • Cost per outpatient day.		• Staffing patterns. • Number of patients below the poverty line. • Inventory / Store management maintenance mechanism.

• Furniture. • Stationery for correspondences. • Staff (Sanctions, Vacancies and Absentees) Doctors Staff Nurses Auxiliary Nurse Midwives (ANM) Lab Technicians Peons Ayahs Sweepers Drivers Dhobhi's (Contracted) • Capacity Building Type of training programme. Periodicity of training. Number of people trained. • Financial Salaries budget Maintenance budget - Equipment Maintenance budget –Building Drugs budget. Equipment budget. Training Budget. Fuel and vehicle maintenance budget User fees Laundry budget Contractual Services budget Miscellaneous expenditure budget	• Number of complaints. • Number of outpatients per day. • Number of referrals. • Number of prescription slips issued • Number of visits by the health officer/ supervisor • Use of equipments	• Display board of available drugs. • Amount of user fees collected. • Bed occupancy rate. • Number of deaths due to sterlisation	• Utilisation of user fees. • Percentage of high risk cases among deliveries • Number of complaints received to number of complaints redressed		

JANAAROGYA ANDOLANA – KARNATAKA

People's campaign towards Health for all "Now"!

Ref: CHC: /03 23rd July 2003

Dear Friends,

Subject: mid day meal scheme by the Government of Karnataka

Greetings from Janarogya Andolana, Bangalore Urban (JABU)!

As many of us already know, Government of Karnataka has introduced the Midday Meal Scheme, which would certainly have an impact on the child's general nutrition status. There is a definite need to understand the implementation of this programme and identify various ways for strengthening it.

To deliberate upon the Scheme, we shall be meeting on 31st **July 2003** between **2:30 pm – 5:30 pm**

Venue:
Christian Medical Association of India,
No 21, III floor HVS Court, opp to Indian Express
Cunningham Road,
Bangalore, 560 001

Ph.: +91 80 2205467

Dr. Archana Mehandale,
Dr. Vasavi, Fellow at National Institute of Advanced Studies, and
Dr. Veda Zechariah, of the Sanjeevini Trust, will facilitate the discussions.

Kindly confirm your participation at the earliest. Looking forward to meeting you.

With best wishes

Yours sincerely

S.J. Chander
For Community Health Cell, Bangalore

Address for Correspondence
Community Health Cell, 367, Srinivasa Nilaya, Jakkasandra, I main, I Block, Koramangala, Bangalore – 560 034
Phone : 080 - 553 1518 Telefax: 552 5372- E-mail sochara@vsnl.com
Bharat Gyan Vigyan Samithi, IISC Campus, Bangalore – 560 012, Phone : 080 360 0384- e-mail: bgvs_kar@hotmail.com

MID DAY MEAL SURVEY, 2003
Part 4: Headmaster Questionnaire (contd...)

1. All children

Total attendance for each day of the month of February

Total Attendance	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	29	30	31
Class I Year 2003(this year)																														
Classes I-V Year 2003(this year)																														
Class I Year 2002(last year)																														
Classes I-V Year 2002(last year)																														

2. SC/ST Children only

Total attendance (SC/ST children) for each day of the month of February

Total Attendance	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	29	30	31
Class I Year 2003(this year)																														
Classes I-V Year 2003(this year)																														
Class I Year 2002(last year)																														
Classes I-V Year 2002(last year)																														

Investigator please note:

1. Take the calendar month preceding the survey. For example, January if the survey takes place in February and February if the survey takes place in March.
2. Remember to enter the month in the space provided above the tables.
3. For Sundays and other holidays please put a cross "X" in the relevant cell(s).
4. If figures are missing for a particular day, write "M" in the relevant cell(s). **Do not leave any cells blank.**

ಮಧ್ಯಾಹ್ನದ ಊಟ ಕುರಿತು ಸರ್ವೇಕ್ಷಣೆ – 2003

Mid Day Meal Survey - 2003

ಭಾಗ 5 : 'ಅಡುಗೆ ಮಾಡುವವರಿಗಾಗಿ' ಪ್ರಶ್ನಾವಳಿ

PART 5: "COOKS" QUESTIONNAIRE

ದಿನಾಂಕ : _____ ಮಾಹಿತಿ ಸಂಗ್ರಹಿಸುವವರ ಹೆಸರು : _____

DATE NAME OF THE INVESTIGATOR

ದಿನಾಂಕ : _____ ಮಾಹಿತಿ ಸಂಗ್ರಹಿಸುವವರ ಹೆಸರು : _____

DATE NAME OF THE INVESTIGATOR

ಹಳ್ಳಿಯ ಹೆಸರು	
ಪಂಚಾಯಿತಿ	
ಘಟಕ (ಬ್ಲಾಕ್)	
ಜಿಲ್ಲೆ	
ರಾಜ್ಯ	ಕರ್ನಾಟಕ

I. ಸಾಮಾನ್ಯ ವಿವರಗಳು GENERAL INFORMATION

1.	ಅಡುಗೆಯವರ ಹೆಸರು			
2	ಲಿಂಗ	ಗಂಡಸು	(1)	—
		ಹೆಂಗಸು	(2)	
3.	ವಯಸ್ಸು			
4	ವಿವಾಹ ವಿಚಾರಗಳು	ವಿವಾಹವಾಗಿದೆ	(1)	☐
		ವಿವಾಹವಾಗಿಲ್ಲ	(2)	
		ವಿಚ್ಛೇದಿತರು	(3)	
		ಬೇರೆ ಬೇರೆಯಾಗಿದ್ದಾರೆ	(4)	
		ವಿಧವೆ / ವಿಧುರ	(5)	
		ಇತರೆ	(6)	
		ಉತ್ತರವಿಲ್ಲ NR	(7)	
5	ಜಾತಿ / ಸಮುದಾಯದ ಹೆಸರು			
6	ಜಾತಿ / ಸಮುದಾಯದ (ಪಂಗಡ)	ಎಸ್.ಸಿ.	(1)	
		ಎಸ್.ಟಿ	(2)	
		ಒ.ಬಿ.ಸಿ	(3)	
		ಸಾಮಾನ್ಯ ವರ್ಗ	(4)	
		ಮುಸುಲ್ಮಾನರು	(5)	
		ಇತರೆ (ಸ್ಪಷ್ಟ ಮಾಡಿ)	(6)	
		ಉತ್ತರವಿಲ್ಲ NR	(7)	

7	ಅದೇ ಹಳ್ಳಿಯ ನಿವಾಸಿಯೇನು?	ಹೌದು	(1)	
		ಇಲ್ಲ	(2)	
		ಉತ್ತರವಿಲ್ಲ NR	(3)	

II. ಮಧ್ಯಾಹ್ನದ ಊಟ ಯೋಜನೆ.

8	ಒಂದು ವಾರದಲ್ಲಿ ಸಾಮಾನ್ಯವಾಗಿ ಎಷ್ಟುಬಾರಿ ಬಿಸಿ ಊಟವನ್ನು ಶಾಲೆಯಲ್ಲಿ ನೀಡುತ್ತಾರೆ?	ಪ್ರತಿದಿನ (ರಜಾದಿನಗಳನ್ನು ಬಿಟ್ಟು)	(1)	
		ಸಾಮಾನ್ಯವಾಗಿ ಎಲ್ಲ ದಿನಗಳು (4-6ದಿನಗಳು)	(2)	
		ಕೆಲವು ದಿನಗಳು (2-3 ದಿನಗಳು)	(3)	
		ಇಲ್ಲವೇ ಇಲ್ಲ	(4)	
		ಉತ್ತರವಿಲ್ಲ NR	(5)	
9	ಅಡುಗೆಯನ್ನು ಎಲ್ಲಿ ಮಾಡುತ್ತೀರಿ?	ಕೇಂದ್ರ ಅಡುಗೆಮನೆಯಲ್ಲಿ	(1)	
		ಶಾಲೆಯ ಆವರಣದಲ್ಲಿ ಇರುವ ಶೆಡ್ / ಅಡುಗೆ ಕೋಣೆಯಲ್ಲಿ	(2)	
		ಶಾಲಾ ಆವರಣದಲ್ಲಿ ಇರುವ ತಾತ್ಕಾಲಿಕ ಶೆಡ್‌ನಲ್ಲಿ	(3)	
		ಶಾಲೆಯ ಬಯಲಿನಲ್ಲಿ	(4)	
		ಅಡುಗೆಮಾಡುವವರ ಮನೆಚುಲ್ಲಿ	(5)	
		ಇತರೆ (ವಿವರಿಸಿ)	(6)	
		ಉತ್ತರವಿಲ್ಲ NR	(7)	
10	ಶಾಲಾ ಆವರಣದ ಹೊರಗೆ ಅಡುಗೆ ಮಾಡುತ್ತಿದ್ದರೆ, ಅಡುಗೆಯನ್ನು ನೀವು ಶಾಲೆಗೆ ಹೇಗೆ ತೆಗೆದುಕೊಂಡು ಬರುತ್ತೀರಿ. ದಯಮಾಡಿ ವಿವರಿಸಿ			
11	ಅಡುಗೆಯ ಕಾಳು-ಬೇಳೆಗಳನ್ನು ಎಲ್ಲಿ ಇಡಲಾಗಿದೆ?	ಶಾಲೆಯಲ್ಲಿ (ತರಗತಿ / ವರಾಂಡ/ಕಛೇರಿ)	(1)	
		ಶಾಲಾ ಆವರಣದಲ್ಲಿರುವ ಗೊದಾಮು	(2)	
		ಹಳ್ಳಿಯ ಬೇರೆ ಕಡೆ ಗೋದಾಮು	(3)	
		ಸರಪಂಚರ ಮನೆಯಲ್ಲಿ	(4)	
		ಶಿಕ್ಷಕರ ಮನೆ	(5)	
		ಅಡುಗೆಯವರ ಮನೆಯಲ್ಲಿ	(6)	
		ಹಳ್ಳಿಯ ನ್ಯಾಯಬೆಲೆ ಅಂಗಡಿಯಲ್ಲಿ	(7)	
		ಇತರೆ (ವಿವರಿಸಿ)	(8)	
		ಉತ್ತರವಿಲ್ಲ	(9)	

12	ಎಲ್ಲ ಪದಾರ್ಥಗಳ ಬಗ್ಗೆ ದಾಖಲೆಯಿದೆಯೇನು?	ಹೌದು	(1)
		ಇಲ್ಲ	(2)
		ಉತ್ತರವಿಲ್ಲ NR	(3)
13	ಹೌದಾದಲ್ಲಿ ಯಾರು ಈ ದಾಖಲೆ ಇಡುತ್ತಾರೆ? ಎಷ್ಟು ಉತ್ತರಗಳನ್ನು ಬೇಕಾದರೂ ಗುರುತು ಹಾಕಿ	ಅಡುಗೆಯವರು	(1)
		ಶಿಕ್ಷಕರು	(2)
		ಶಾಲಾ ಸಮಿತಿ	(3)
		ಸರಪಂಚರು	(4)
		ಇತರೆ (ವಿವರಿಸಿ)	(5)
		ಉತ್ತರವಿಲ್ಲ NR	(6)
14	ಅಡುಗೆ ಮಾಡಲು ಯಾವ ಉರುವಲನ್ನು ಬಳಸುತ್ತೀರಿ?	ಕಟ್ಟಿಗೆ	(1)
		ಸೀಮೇ ಎಣ್ಣೆ	(2)
		ಗ್ಯಾಸ್	(3)
		ಇತರೆ (ವಿವರಿಸಿ)	(4)
		ಉತ್ತರವಿಲ್ಲ	(5)
15	ನಿಮಗೆ ಉರುವಲನ್ನು ನೀಡಲಾಗುತ್ತದೆಯೆ?	ಹೌದು	(1)
		ಇಲ್ಲ	(2)
		ಉತ್ತರವಿಲ್ಲ NR	(3)
16	ಇಲ್ಲ ಎಂದಾದಲ್ಲಿ, ಯಾವ ವ್ಯವಸ್ಥೆ ಮಾಡಲಾಗಿದೆ? ವಿವರಿಸಿ		

III. ಮಧ್ಯಾಹ್ನದ ಊಟ ತಯ್ಯಾರಿ ಪ್ರಕ್ರಿಯೆ Process of cooking the MDM

17	ಏನು ಅಡುಗೆ ಮಾಡಬೇಕೆಂದು ಹೇಗೆ ನಿರ್ಧರಿಸುತ್ತೀರಿ? (ಎಷ್ಟು ಉತ್ತರಗಳಿಗೆ ಬೇಕಾದರೂ ಗುರುತು ಹಾಕಿ)	ಸರ್ಕಾರದ ನಿರ್ದೇಶನವನ್ನು ಪಾಲಿಸುತ್ತೇವೆ	(1)
		ಮುಖ್ಯೋಪಾಧ್ಯಾಯರು ಹೇಳಿದಂತೆ	(2)
		ಶಾಲಾ ಸಮಿತಿ ಹೇಳಿದಂತೆ	(3)
		ಸ್ವಯಂ ನಿರ್ಧಾರ	(4)
		ಇತರೆ (ವಿವರಿಸಿ)	(5)
		ಉತ್ತರವಿಲ್ಲ	(6)
18	ಮಧ್ಯಾಹ್ನದ ಊಟಕ್ಕಾಗಿ ಅಡುಗೆ ಮಾಡುವ ಪ್ರಕ್ರಿಯೆಯನ್ನು ವಿವರಿಸಿ (ಮಾಹಿತಿ ಸಂಗ್ರಹಿಸುವವರೆ ಈ ಮುಂದಿನವುಗಳ ಬಗ್ಗೆ ಗಮನವಿರಲಿ: ಕಾಳು, ಬೇಳೆ ಮತ್ತಿತರ ಆಹಾರ ಪದಾರ್ಥಗಳನ್ನು ಪಡೆಯುವಲ್ಲಿ ಇರುವ ನಿರಂತರತೆ, ಯಾರು ಕೊಡುತ್ತಾರೆ, ಇತ್ಯಾದಿ)			
19.a	ಪ್ರತಿದಿನ ಒಂದೇ ಪ್ರಮಾಣದಲ್ಲಿ ಅಡುಗೆ ಮಾಡುತ್ತೀರೇನು?	ಹೌದು	(1)
		ಇಲ್ಲ	(2)

		ಉತ್ತರವಿಲ್ಲ NR	(3)
19.b	ಹೌದಾದಲ್ಲಿ, ಒಟ್ಟು ಎಷ್ಟು ಪ್ರಮಾಣ?		
19c.	ಇಲ್ಲ ಎಂದಾದಲ್ಲಿ, ಆ ಪ್ರಮಾಣವನ್ನು ಹೇಗೆ ನಿರ್ಧರಿಸುತ್ತೀರಿ?		
20.	ಮಕ್ಕಳೆಲ್ಲಾ ಊಟ ಮಾಡಿದಮೇಲೂ ಅಡುಗೆ ಉಳಿದು ಹೋಗುವ ಪ್ರಸಂಗಗಳು ಸಾಮಾನ್ಯವಾಗಿ ಎಷ್ಟು ಬಾರಿ ಆಗುತ್ತದೆ?	ಪ್ರತಿದಿನ ಸಾಮಾನ್ಯವಾಗಿ ಎಲ್ಲ ದಿನಗಳು ಕೆಲವು ದಿನಗಳು ಎಂದೂ ಇಲ್ಲ ಉತ್ತರವಿಲ್ಲ	(1) (2) (3) (4) (5)
21.	ಎಂದಾದರೂ ಅಡುಗೆ ಉಳಿದು ಹೋದರೆ, ಏನು ಮಾಡುತ್ತೀರಿ? (ಒಂದಕ್ಕಿಂತಾ ಹೆಚ್ಚು ಉತ್ತರಗಳನ್ನು ಗುರುತಿಸಬಹುದು)	ಬಿಸಾಕುತ್ತೇವೆ ಮಕ್ಕಳಿಗೇ ಕೊಟ್ಟುಬಿಡುತ್ತೇವೆ ಹಳ್ಳಿಯಲ್ಲಿರುವ ಪ್ರಾಥಮಿಕ ಶಾಲೆಯ ಮಕ್ಕಳಲ್ಲದ ಅನಾಥರಿಗೆ ಕೊಟ್ಟುಬಿಡುತ್ತೇವೆ. ಅಡುಗೆಯವರೇ ತೆಗೆದುಕೊಂಡು ಹೋಗುತ್ತಾರೆ. ಶಿಕ್ಷಕರು ತೆಗೆದುಕೊಂಡು ಹೋಗುತ್ತಾರೆ. ಇತರೆ (ವಿವರಿಸಿ) ಉತ್ತರವಿಲ್ಲ	(1) (2) (3) (4) (5) (6) (7)
22	ಮಾಡಿದ ಅಡುಗೆ ಸಾಕಾಗದ ಸಂದರ್ಭಗಳು ಎಷ್ಟು ಬಾರಿ ಬರುತ್ತದೆ?	ಹಾಗಾಗುವುದೇ ಇಲ್ಲ ಅಪರೂಪಕ್ಕೊಮ್ಮೆ ಆಗಾಗ್ಗೆ ಸಾಮಾನ್ಯ ಮೇಲಿಂದ ಮೇಲೆ ಹೆಚ್ಚೂ ಕಡಿಮೆ ಪ್ರತಿದಿನ ಉತ್ತರವಿಲ್ಲ	(1) (2) (3) (4) (5) (6)
23.	ಮಾಡಿದ ಅಡುಗೆ ಕಡಿಮೆ ಬಿದ್ದಾಗ ಏನು ಮಾಡುವಿರಿ?		
24	ಅಡುಗೆ ಮಾಡಲು ಮತ್ತು ಮಕ್ಕಳಿಗೆ ಬಡಿಸಲು ನಿಮಗೆ ಸಹಾಯಕರನ್ನು ಒದಗಿಸಲಾದೆಯೆ?	ಹೌದು ಇಲ್ಲ ಉತ್ತರವಿಲ್ಲ NR	(1) (2) (3)
25	ಒದಗಿಸಲಾಗಿದ್ದರೆ, ಎಷ್ಟು ಜನರಿದ್ದಾರೆ?	ಒಬ್ಬರು ಇಬ್ಬರು ಇಬ್ಬರಿಗಿಂತಾ ಹೆಚ್ಚು ಇಲ್ಲ ಉತ್ತರವಿಲ್ಲ	(1) (2) (3) (4) (5)
26	ಇಷ್ಟು ಸಾಕೆ ? ಅಥವಾ ಇನ್ನೂ ಹೆಚ್ಚಿನ ಸಂಖ್ಯೆಯಲ್ಲಿ ಸಹಾಯಕರು ಬೇಕೆ?	ಸಾಕು	(1)

		ಹೆಚ್ಚಿನವರು ಬೇಕು	(2)
		ಉತ್ತರವಿಲ್ಲ	(3)
27	ಶಿಕ್ಷಕರನ್ನು ಹೊರತು ಪಡಿಸಿ, ಅಡುಗೆ ಕೆಲಸಗಳ ಮೇಲುಸ್ತುವಾರಿ ಮಾಡಲು, ಸಂಯೋಜಿಸಲು ಮತ್ತು ಅಡುಗೆ ಮನೆಯ ಲೆಕ್ಕಪತ್ರಗಳನ್ನು ನೋಡಲು ಯಾರಾದರೂ ಇದ್ದಾರೇನು?	ಹೌದು	(1)
		ಇಲ್ಲ	(2)
		ಉತ್ತರವಿಲ್ಲ NR	(3)
28	ಅಡುಗೆ ಮಾಡಲು ಶಿಕ್ಷಕ ವರ್ಗದವರೂ ಸೇರುತ್ತಾರೇನು?	ಹೌದು	(1)
		ಇಲ್ಲ	(2)
		ಉತ್ತರವಿಲ್ಲ NR	(3)
29.	ಹೌದಾದಲ್ಲಿ, ಹೇಗೆ ಸೇರುತ್ತಾರೆ? (ಒಂದಕ್ಕಿಂತಾ ಹೆಚ್ಚಿನ ಉತ್ತರಗಳನ್ನು ಗುರುತಿಸಬಹುದು)	ಅಡುಗೆ ಮಾಡುವುದರಲ್ಲಿ	(1)
		ತರಕಾರಿ ಹೆಚ್ಚುವುದು	(2)
		ಉರುವಲು ತರಲು	(3)
		ಪಾತ್ರೆ ತೊಳೆಯುವುದು	(4)
		ಆಹಾರ ವಿತರಣೆ	(5)
		ಇತರೆ (ವಿವರಿಸಿ)	(6)
		ಉತ್ತರವಿಲ್ಲ	(7)
30.	ಅಡುಗೆ ಮಾಡುವಲ್ಲಿ ಮಕ್ಕಳ ಭಾಗವಹಿಸುವೆ ಯಾವುದರಲ್ಲಿದೆ? (ಹೆಚ್ಚು ಉತ್ತರಗಳನ್ನು ಗುರುತು ಹಾಕಬಹುದು)	ಅಡುಗೆ ಮಾಡುವಲ್ಲಿ	(1)
		ತರಕಾರಿ ಹೆಚ್ಚುವುದು	(2)
		ಉರುವಲು ಸಂಗ್ರಹ	(3)
		ಪಾತ್ರೆ ತೊಳೆಯುವುದು	(4)
		ಆಹಾರ ವಿತರಣೆ	(5)
		ನೀರು ತರುವುದು	(6)
		ಇತರೆ (ವಿವರಿಸಿ)	(7)
		ಉತ್ತರವಿಲ್ಲ	(8)

IV. ಅಡುಗೆಯವರ ನೇಮಕ ಮತ್ತು ಸಂಬಳ Cook's appointment and salary

IV. ಅಡುಗೆಯವರ ನೇಮಕ ಮತ್ತು ಸಂಬಳ

31.	ನಿಮ್ಮನ್ನು ಅಡುಗೆಯವರಾಗಿ ಯಾವಾಗ ನೇಮಕ ಮಾಡಲಾಯಿತು? ತಿಂಗಳು: ವರ್ಷ:		
32.	ನಿಮ್ಮನ್ನು ನೇಮಕ ಮಾಡಿದವರು ಯಾರು? ನೇಮಕ ಮಾಡಿದ ರೀತಿಯನ್ನು ವಿವರಿಸಿ?		
33.	ನಿಮ್ಮ ಅನಿಸಿಕೆಯ ಪ್ರಕಾರ, ನೀವು ಯಾವ ಕಾರಣದಿಂದ ಅಡುಗೆಯವರಾಗಿ ಇಲ್ಲಿ ಆಯ್ಕೆಗೊಂಡಿರಿ?		
34.	ನಿಮ್ಮ ಅನಿಸಿಕೆಯ ಪ್ರಕಾರ, ನೀವು ಅಡುಗೆಯವರಾಗಿ ಆಯ್ಕೆಯಾಗಲು ಯಾರು ಮುಖ್ಯ ಪಾತ್ರ ವಹಿಸಿದರು?		
35.	ನಿಮಗೆ ತಿಂಗಳಿಗೆ ಬರುವ ಸಂಬಳವೆಷ್ಟು?		
36.	ನಿಮಗೆ ಬರಬೇಕಾದ ಸಂಬಳ ಬಾಕಿ ಇದೆಯೇ?	ಹೌದು (1) ಇಲ್ಲ (2) NR (3)	---------
37.	ಹೌದು ಎಂದಾದರೆ ನಿಮಗೆ ಎಷ್ಟು ತಿಂಗಳ ಸಂಬಳ ಬಾಕಿ ಇದೆ?		

V. ಆಹಾರ ವಿತರಣೆ			
38.	ಊಟ ನೀಡುವಾಗ ಮಕ್ಕಳು ಕುಳಿತುಕೊಳ್ಳುವಲ್ಲಿ ಏನಾದರೂ ನಿರ್ದಿಷ್ಟ ರೀತಿ ಇದೆಯೇನು?(ಎಷ್ಟು ಉತ್ತರಗಳಿಗೆ ಬೇಕಾದರೂ ಗುರುತು ಹಾಕಿ)	ಹುಡುಗರು – ಹುಡುಗಿಯರು ಪ್ರತ್ಯೇಕವಾಗಿ (1) ಬೇರೆ ಬೇರೆ ತರಗತಿಯ ಮಕ್ಕಳು ಪ್ರತ್ಯೇಕವಾಗಿ (2) ಬೇರೆ ಬೇರೆ ಜಾತಿಯ ಮಕ್ಕಳು ಪ್ರತ್ಯೇಕವಾಗಿ (3) ಎಲ್ಲಾ ಮಕ್ಕಳು ಜೊತೆಯಾಗಿ (4) ಇತರೆ(ವಿವರಿಸಿ) (5) ಉತ್ತರವಿಲ್ಲ NR (6)	-------- -------- -------- -------- --------
39.	ಆಹಾರವನ್ನು ಹೇಗೆ ಬಡಿಸಲಾಗಿದೆ? ವಿವರಿಸಿ? (ಮಾಹಿತಿ ಸಂಗ್ರಹಿಸುವವರು, ದಯವಿಟ್ಟು ಯಾರು ಊಟವನ್ನು ಬಡಿಸುತ್ತಿದ್ದಾರೆ ಮತ್ತು ಬೇರೆ ಬೇರೆ ಜಾತಿಯ ಮಕ್ಕಳಿಗೆ ಬೇರೆ ಬೇರೆ ರೀತಿಯಲ್ಲಿ ಬಡಿಸುತ್ತಿದ್ದಾರೆಯೋ ಇಲ್ಲವೊ ಎಂದು ಗಮನಿಸಿ.)		
V1.ಮಧ್ಯಾಹ್ನದ ಊಟ ಯೋಜನೆಯ ಸಮಸ್ಯೆಗಳು			
40.	ಮಧ್ಯಾಹ್ನದ ಊಟದ ಯೋಜನೆಯನ್ನು ಮುಂದುವರಿಸಬೇಕೆಂದು ನೀವು ಯೋಚಿಸುತ್ತೀರಾ?	ಹೌದು (1) ಇಲ್ಲ (2) NR (3)	----------
41.	ಬೇಡ ಎಂದು ಹೇಳಿದಲ್ಲಿ, ಯಾಕೆ? ವಿವರಿಸಿ?		
42.	ಮಧ್ಯಾಹ್ನದ ಊಟದ ಯೋಜನೆಯಲ್ಲಿ ಅಡಿಗೆ ಮಾಡಲು ಮತ್ತು ಬಡಿಸಲು ಏನಾದರೂ ಸಮಸ್ಯೆಗಳಿವೆಯೇ?ದಯವಿಟ್ಟು ವಿವರಿಸಿ.		

ಮಧ್ಯಾಹ್ನದ ಊಟದ ಸಮೀಕ್ಷೆ – 2003

ಭಾಗ 3: "ಶಾಲಾ ಸುಧಾರಣಾ ಸಮಿತಿ" ಪ್ರಶ್ನಾವಳಿ

ದಿನಾಂಕ :		ಪರಿಶೋಧಕನ ಹೆಸರು :
ಹಳ್ಳಿಯ ಹೆಸರು :		ಪಂಚಾಯತ :
ಕ್ಷೇತ್ರ (ಬ್ಲಾಕ್) :		ಜಿಲ್ಲೆ:
ರಾಜ್ಯ:		
I ಸಾಮಾನ್ಯ ಮಾಹಿತಿ:		
೧. ಪ್ರತಿಕ್ರಿಯಿಸುವವನ/ಳ ಹೆಸರು:		
೨. ಹಳ್ಳಿಯ ಶಾಲಾ ಸುಧಾರಣಾ ಸಮಿತಿಯಲ್ಲಿ ಇವರ ಹುದ್ದೆ:		
II ಹಳ್ಳಿ ವಿದ್ಯಾ ಸಮಿತಿಯ ರಚನೆ		
೩. ಹಳ್ಳಿ ಶಾಲಾ ಸುಧಾರಣಾ ಸಮಿತಿಯಲ್ಲಿ ಎಷ್ಟುಜನ ಸದಸ್ಯರಿದ್ದಾರೆ?		☐
೪ ಅವರಲ್ಲಿ ಎಷ್ಟು ಜನ ಪರಿಸಿಷ್ಟ ಜಾತಿ/ ಪರಿಸಿಷ್ಟ ಪಂಗಡಕ್ಕೆ ಸೇರಿರುತ್ತಾರೆ?		☐
III ಮಧ್ಯಾಹ್ನದ ಊಟ ಕಾರ್ಯಕ್ರಮದ ಬಗ್ಗೆ ಸಾಮಾನ್ಯ ಪ್ರಶ್ನೆಗಳು		
೫. ತಯಾರಿಸಿದ ಊಟವನ್ನು ಶಾಲೆಯಲ್ಲಿ ಎಷ್ಟು ಬಾರಿ ನೀಡುತ್ತಾರೆ?	೧ ಪ್ರತಿ ದಿನ (ರಜೆ ದಿನಗಳನ್ನು ಬಿಟ್ಟು) ೨ ಬಹು ಪಾಲು ದಿನ ೩ ಆಗಾಗ ೪ ನೀಡುವುದೇ ಇಲ್ಲಾ ೫ ಪ್ರತಿಕ್ರಿಯೆಯಿಲ್ಲ	☐
೬. ಮಧ್ಯಾಹ್ನದ ಊಟಕ್ಕೆ ಸಂಭಂಧಿಸಿದಂತೆ, ಹಳ್ಳಿ ಶಾಲಾ ಸುಧಾರಣಾ ಸಮಿತಿಯ ನಿರ್ದಿಷ್ಟ ಕಾರ್ಯಗಳೇನು ?		

IV ಜಾತಿಬೇಧ		
೭. ತಮ್ಮ ಮಕ್ಕಳು ಬೇರೆ ಜಾತಿಮಕ್ಕಳೊಟ್ಟಿಗೆ ಊಟ ಮಾಡುವುದನ್ನು ಯಾವುದೇ ಮೇಲ್ಜಾತಿಯ ಪೋಷಕರು ವಿರೋಧಿಸಿದ್ದಾರಾ?	೧ ಹೌದು ೨ ಇಲ್ಲ ೩ ಪ್ರತಿಕ್ರಿಯೆ ಇಲ್ಲ	☐
೮. ಹೌದಾದರೇ, ಅದು ಹೇಗೆ ಪರಿಹಾರವಾಗಿದೆ (ಅಗತ್ಯವಿದ್ದಲ್ಲಿ ಒಂದಕ್ಕಿಂತ ಹೆಚ್ಚು ಆಂಶಗಳನ್ನು ಗುರುತಿಸಿ)	೧ ಬೇರೆ ಬೇರೆ ಜಾತಿಯ ಮಕ್ಕಳಿಗೆ ಪ್ರತ್ಯೇಕ ಕೂಡುವ / ಊಟದ ವ್ಯವಸ್ಥೆ. ೨ ಕೆಳಜಾತಿಯ ಮಕ್ಕಳಿಗೆ ಮಧ್ಯಾಹ್ನದ ಊಟ ಕೊಡದಿರುವುದು ೩ ಮಧ್ಯಾಹ್ನದ ಊಟಕ್ಕೆ ಮೇಲ್ಜಾತಿಯ ಮಕ್ಕಳು ಭಾಗವಹಿಸುವುದಿಲ್ಲ ೪ ಬೇರೆ ಬೇರೆ ಜಾತಿಗಳಿಗೆ ಪ್ರತ್ಯೇಕ ಅಡಿಗೆ ೫ ಇತರೆ (ದಯವಿಟ್ಟು ವಿವರಿಸಿ)	☐ ☐ ☐ ☐ ☐
೯. ಪರಿಹಾರವಾಗದಿದ್ದಲ್ಲಿ, ಇದಕ್ಕೆ ಪರಿಹಾರವಿದೆಯೆಂದು ನಿಮಗನ್ನಿಸುತ್ತದೆಯೇ?	೧ ಹೌದು ೨ ಇಲ್ಲ ೩ ಪ್ರತಿಕ್ರಿಯೆ ಇಲ್ಲ	☐
೧೦. ಇದು ಪರಿಹಾರವಾಗುವುದೇ ಇಲ್ಲವೆಂದರೇ, ಏಕೆ? (ದಯವಿಟ್ಟು ವಿವರಿಸಿ)		
೧೧. ಮೇಲ್ಜಾತಿಯ ಮಕ್ಕಳು, ಬೇರೆ ಜಾತಿಯ ಮಕ್ಕಳೊಟ್ಟಿಗೆ ಊಟ ಮಾಡಲು ಅಸಂತೋಷವನ್ನು ವ್ಯಕ್ತಪಡಿಸಿದ್ದಾರೆಯೇ?	೧ ಹೌದು ೨ ಇಲ್ಲ ೩ ಪ್ರತಿಕ್ರಿಯೆ ಇಲ್ಲ	☐
೧೨. ಸಾಮೂಹಿಕ ಭೋಜನದ ವಿಷಯವಾಗಿ ಪಂಚಾಯತಿಯಲ್ಲಿ ಸಮಸ್ಯೆ ಬಂದಿದೆಯೇ?	೧ ಹೌದು ೨ ಇಲ್ಲ ೩ ಪ್ರತಿಕ್ರಿಯೆ ಇಲ್ಲ	☐
೧೩. ಪಂಚಾಯತಿಯಲ್ಲಿ ಅದಕ್ಕಾದ ಪರಿಷ್ಕಾರವೇನು?		

೧೪. ಬೇರೆ ಜಾತಿಯವರಿಗೆ ಪ್ರತ್ಯೇಕ ನೀರಿನ ವ್ಯವಸ್ಥೆಯಿದೆಯೇ?	೧ ಹೌದು ೨ ಇಲ್ಲ ೩ ಪ್ರತಿಕ್ರಿಯೆ ಇಲ್ಲ	☐
ಪರಿಶೋಧಕನ/ಳ ಟಿಪ್ಪಣಿ		

ಮಧ್ಯಾಹ್ನದ ಊಟ ಕುರಿತು ಸರ್ವೇಕ್ಷಣೆ – 2003

Mid Day Meal Survey - 2003

ಭಾಗ 6 : 'ಪೋಷಕರ ಅಭಿಪ್ರಾಯಗಳಿಗಾಗಿ ಪ್ರಶ್ನಾವಳಿ'

PART 6: "PARENTS" QUESTIONNAIRE

ದಿನಾಂಕ : _____ ಮಾಹಿತಿ ಸಂಗ್ರಹಿಸುವವರ ಹೆಸರು : _____

DATE NAME OF THE INVESTIGATOR

ಹಳ್ಳಿಯ ಹೆಸರು	
ಪಂಚಾಯಿತಿ	
ಘಟಕ (ಬ್ಲಾಕ್)	
ಜಿಲ್ಲೆ	
ರಾಜ್ಯ	ಕರ್ನಾಟಕ

I. ಸಾಮಾನ್ಯ ವಿವರಗಳು GENERAL INFORMATION

1.	ಮನೆಯ ಮುಖ್ಯಸ್ಥರ ಹೆಸರು			
2.	ವಯಸ್ಸು			
3	ವಿವಾಹ ವಿಚಾರಗಳು	ವಿವಾಹವಾಗಿದೆ	(1)	☐
		ವಿವಾಹವಾಗಿಲ್ಲ	(2)	
		ವಿಚ್ಛೇದಿತರು	(3)	
		ಬೇರೆ ಬೆರಯಾಗಿದ್ದಾರೆ	(4)	
		ವಿಧವೆ / ವಿಧುರ	(5)	
		ತೊರೆಯಲ್ಪಟ್ಟಿದ್ದಾರೆ	(6)	
4	ಜಾತಿ / ಸಮುದಾಯದ ಹೆಸರು			
5	ಜಾತಿ/ ಸಮುದಾಯ (ಗುಂಪು)	ಎಸ್.ಸಿ.	(1)	☐
		ಎಸ್.ಟಿ	(2)	
		ಒ.ಬಿ.ಸಿ	(3)	
		ಸಾಮಾನ್ಯ ವರ್ಗ	(4)	
		ಮುಸುಲ್ಮಾನರು	(5)	
		ಇತರೆ (ಸ್ಪಷ್ಟ ಮಾಡಿ)	(6)	
6.	ಮುಖ್ಯ ವೃತ್ತಿ	ಸ್ವಯಂ ಉದ್ಯೋಗ (ಕೃಷಿ)	(1)	☐
		ದಿನಗೂಲಿ	(2)	
		ಸ್ವಯಂ ಉದ್ಯೋಗ (ಕೃಷಿಯೇತರ)	(3)	
		ನೌಕರಿ	(4)	
		ಇತರೆ (ಸ್ಪಷ್ಟ ಮಾಡಿ)	(5)	
7	ಅವರಿಗಿರುವ ಒಟ್ಟು ಭೂಮಿ (ಎಕರೆಗಳಲ್ಲಿ)			

8	ಹಳ್ಳಿಯ ಇತರ ಕುಟುಂಬಗಳಿಗೆ ಹೋಲಿಸಿದರೆ, ಈ ಕುಟುಂಬದವರ ಆರ್ಥಿಕ ಸ್ಥಿತಿಯನ್ನು ನೀವು ಹೇಗೆ ಸರಾಸರಿಯಲ್ಲಿ ಹೇಳುತ್ತೀರಿ.	ಕಡುಬಡವರಿರುವ ಶೇ.೨೦ ರ ಭಾಗದವರು ಇತರ	(1)	
		ಸರಾಸರಿಗಿಂತ ಬಡವರು	(2)	
		ಪರವಾಗಿಲ್ಲ (ಸರಾಸರಿ)	(3)	
		ಸರಾಸರಿಗಿಂತ ಪರವಾಗಿಲ್ಲ, ಆದರೆ ಖಚಿಡಿತಾ ಅತ್ಯುತ್ತಮವಾದ ಶೇ.೨೦ ರ ಭಾಗದಲ್ಲಿಲ್ಲ	(4)	
		ಅತ್ಯುತ್ತಮವಾದ ಶೇ.೨೦ ರ ಭಾಗದಲ್ಲಿ	(4)	

II. ಮಧ್ಯಾಹ್ನದ ಊಟ ಯೋಜನೆ.

	ಶಾಲೆಯಲ್ಲಿ ನೀಡುವ ಬಿಸಿ ಊಟವನ್ನು ನಿಮ್ಮ ಮಗು ತಿನ್ನುತ್ತಿದೆಯೇ?	ಹೌದು	(1)	
		ಇಲ್ಲ	(2)	
		ಉತ್ತರವಿಲ್ಲ NR	(3)	
9	ಒಂದು ತಿಂಗಳ ಅವಧಿಯಲ್ಲಿ ಸಾಮಾನ್ಯವಾಗಿ ಎಷ್ಟುಬಾರಿ ಬಿಸಿ ಊಟವನ್ನು ಶಾಲೆಯಲ್ಲಿ ನೀಡುತ್ತಾರೆ?	ಪ್ರತಿದಿನ (ರಜಾದಿನಗಳನ್ನು ಬಿಟ್ಟು)	(1)	
		ಸಾಮಾನ್ಯವಾಗಿ ಎಲ್ಲ ದಿನಗಳು (4-6ದಿನಗಳು)	(2)	
		ಕೆಲವು ದಿನಗಳು (2-3 ದಿನಗಳು)	(3)	
		ಇಲ್ಲವೇ ಇಲ್ಲ	(4)	
		ಉತ್ತರವಿಲ್ಲ NR	(5)	
10	ಶಾಲೆಗಳಲ್ಲಿ ಮಧ್ಯಾಹ್ನದ ಊಟ ಆರಂಭ ಆಗಿರುವುದರಿಂದ ಶಾಲೆಗೆ ಹೋಗೆಂದು ನಿಮ್ಮ ಮಕ್ಕಳ ಮನ ಒಲಿಸಲು ಸುಲಭವಾಗಿದೆಯೋ ಅಥವಾ ಕಷ್ಟವಾಗಿದೆಯೋ?	ಅತಿ ಸುಲಭವಾಗಿದೆ	(1)	
		ವ್ಯತ್ಯಾಸವೇನಿಲ್ಲ	(2)	
		ಅತಿ ಕಷ್ಟವಾಗಿದೆ	(3)	
		ಉತ್ತರವಿಲ್ಲ NR	(4)	
11	ಮಧ್ಯಾಹ್ನದ ಊಟಕ್ಕೆ ಮಕ್ಕಳು ಎದುರು ನೋಡುತ್ತಾರೆ ಎಂದು ನಿಮಗನಿಸುತ್ತದೇನು?	ಹೌದು	(1)	
		ಇಲ್ಲ	(2)	
		ಗೊತ್ತಿಲ್ಲ NR	(3)	
12	ಶಾಲೆಯಲ್ಲಿ ಮಧ್ಯಾಹ್ನದ ಊಟ ಮಾಡಿದ ಮೇಲೆ ನಿಮ್ಮ ಮಗುವಿಗೆ ಯಾವಾಗಲಾದರೂ ಹೊಟ್ಟೆ ನೋವು ಅಥವಾ ಇರುಸು ಮುರುಸಾಗಿತ್ತೇನು?	ಹೌದು	(1)	
		ಇಲ್ಲ	(2)	
		ಗೊತ್ತಿಲ್ಲ NR	(3)	
13	ಉತ್ತರ ಹೌದು ಎಂದಾದಲ್ಲಿ, ಹೀಗೆ ಎಷ್ಟು ಬಾರಿ ಆಗಿದೆ?	ಹೆಚ್ಚೂ ಕಡಿಮೆ ಪ್ರತಿದಿನ	(1)	
		ಹಲವಾರು ಬಾರಿ	(2)	
		ಕೆಲವು ಬಾರಿ	(3)	
		ಯಾವಾಗಲಾದರೂ ಒಂದೆರಡು ಬಾರಿ	(4)	
		ಉತ್ತರವಿಲ್ಲ NR	(5)	

14	ಕಳೆದ ಏಳು ದಿನಗಳಲ್ಲಿ ಶಾಲೆಯಲ್ಲಿ ಮಧ್ಯಾಹ್ನದ ಊಟ ಮಾಡಿ ನಿಮ್ಮ ಮಗು ಎಷ್ಟು ಬಾರಿ ಅಸ್ವಸ್ಥವಾಗಿದೆ?	ಇಲ್ಲವೇ ಇಲ್ಲ	(1)	
		ಒಂದು ಬಾರಿ	(2)	
		ಎರಡು ಬಾರಿ	(3)	
		ಎರಡಕ್ಕಿಂತಾ ಹೆಚ್ಚು ಬಾರಿ	(4)	
		ಇತರೆ	(5)	
		ಉತ್ತರವಿಲ್ಲ NR	(6)	
15	ಶಾಲೆಯಲ್ಲಿ ನೀಡುವ ಊಟದ ಗುಣಮಟ್ಟದ ಬಗ್ಗೆ ನಿಮಗೆ ತೃಪ್ತಿ ಇದೆಯೋ ಇಲ್ಲವೋ?	ತೃಪ್ತಿಇದೆ	(1)	
		ಅತೃಪ್ತಿ ಇದೆ	(2)	
		ಉತ್ತರವಿಲ್ಲ NR	(3)	
16	ಯಾಕೆ ? ವಿವರಿಸುತ್ತೀರಾ _			

III. ಜಾತಿ ಬೇಧ Caste Discrimination

17	ಶಾಲೆಯಲ್ಲಿ ವಿವಿಧ ಜಾತಿಯ ಮಕ್ಕಳು ಒಟ್ಟಿಗೆ ಊಟ ಮಾಡುವುದಕ್ಕೆ ನಿಮ್ಮದೇನಾದರೂ ಭಿನ್ನಾಭಿಪ್ರಾಯವಿದೆಯೇ	ಇದೆ	(1)	
		ಇಲ್ಲ	(2)	
		ಉತ್ತರವಿಲ್ಲ NR	(3)	
18	ಭಿನ್ನಾಭಿಪ್ರಾಯವಿದ್ದಲ್ಲಿ, ದಯಮಾಡಿ ವಿವರಿಸಿ			
19	ಶಾಲೆಯಲ್ಲಿ ಮಧ್ಯಾಹ್ನದ ಊಟ ನೀಡುವ ಸಮಯದಲ್ಲಿ ನಿಮ್ಮ ಮಗುವಿಗೇನಾದರೂ ಜಾತಿ ಬೇಧ ಮಾಡಿದ ಅನುಭವವಾಗಿದೆಯೆಂದು ನಿಮಗನ್ನಿಸಿದೆಯೆ ?	ಹೌದು	(1)	
		ಇಲ್ಲ	(2)	
		ಉತ್ತರವಿಲ್ಲ NR	(3)	
20	ಉತ್ತರ ಹೌದಾದಲ್ಲಿ , ವಿವರಿಸಿ			

21	ಊಟ ನೀಡುವಾಗ ಮಕ್ಕಳು ಕುಳಿತುಕೊಳ್ಳುವಲ್ಲಿ ಏನಾದರೂ ನಿರ್ದಿಷ್ಟ ರೀತಿ ಇದೆಯೇನು?	ಹುಡುಗರು – ಹುಡುಗಿಯರು ಪ್ರತ್ಯೇಕವಾಗಿ	(1)	☐
		ಬೇರೆ ಬೇರೆ ತರಗತಿಯ ಮಕ್ಕಳು ಪ್ರತ್ಯೇಕವಾಗಿ	(2)	☐
		ಬೇರೆ ಬೇರೆ ಜಾತಿಯ ಮಕ್ಕಳು ಪ್ರತ್ಯೇಕವಾಗಿ	(3)	☐
		ಎಲ್ಲ ಮಕ್ಕಳು ಜೊತೆಯಾಗಿ	(4)	☐
		ಇತರೆ (ವಿವರಿಸಿ)	(5)	☐
		ಉತ್ತರವಿಲ್ಲ NR	(6)	☐

IV. ವ್ಯವಸ್ಥೆ Infrastructure

22	ಮಧ್ಯಾಹ್ನದ ಊಟ ಮಾಡಲು ಮಕ್ಕಳು ತಟ್ಟೆ ಉಪಯೋಗಿಸುವರೇನು?	ಹೌದು	(1)	☐
		ಇಲ್ಲ	(2)	
		ಉತ್ತರವಿಲ್ಲ NR	(3)	
23	ತಟ್ಟೆಗಳಿಗಾಗಿ ಏನು ವ್ಯವಸ್ಥೆಮಾಡಲಾಗಿದೆ?	ಶಾಲೆಯವರೆ ತಟ್ಟ ಒದಗಿಸಿದ್ದಾರೆ	(1)	☐
		ಇತರೆ (ಉದಾ; ಎಲೆ) ವ್ಯವಸ್ಥೆ ಶಾಲೆ ಮಾಡಿದೆ	(2)	☐
		ಮನೆಯಿಂದ ತಟ್ಟ ಅಥವಾ ಎಲೆ ತೆಗೆದುಕೊಂಡುಹೋಗಬೇಕು	(3)	☐
		ಮಕ್ಕಳೇ ಏನಾದರೊಂದು ತಾತ್ಕಾಲಿಕ ವ್ಯವಸ್ಥೆ ಮಾಡಿಕೊಳ್ಳುತ್ತಾರೆ (ಉದಾ: ಪುಸ್ತಕದಿಂದ ಕಾಗದ ಹರಿದು)	(4)	☐
		ಇತರೆ	(5)	
24	ನೀರಿಗೇನು ವ್ಯವಸ್ಥೆ ಮಾಡಲಾಗಿದೆ	ಶಾಲಾ ಆವರಣದಲ್ಲಿ ನೀರಿನ ಮೂಲವಿದೆ (ಉದಾ: ನಲ್ಲಿ)	(1)	
		ಹತ್ತಿರದಿಂದ ಮಡಿಕೆಯಲ್ಲಿ ತರಲಾಗುತ್ತದೆ.	(2)	
		ನೀರಿರುವ ಕಡೆಗೆ ಮಕ್ಕಳೇ ಹೋಗುತ್ತಾರೆ	(3)	☐
		ಇತರೆ (ವಿವರಿಸಿ)	(4)	
		ಯಾವುದೇ ವ್ಯವಸ್ಥೆ ಇಲ್ಲ	(5)	
		ಉತ್ತರವಿಲ್ಲ NR	(6)	
25	ಶಾಲೆಯಲ್ಲಿ ಮಧ್ಯಾಹ್ನದ ಊಟ ಕೊಡುವುದನ್ನು ಮುಂದುವರಿಸಬೇಕೆ ಅಥವಾ ನಿಲ್ಲಿಸಬೇಕೆ?	ನಿಲ್ಲಿಸಿ	(1)	☐
		ನಿಲ್ಲಿಸಬಾರದು	(2)	

26	ಮುಂದುವರಿಸಬೇಕು ಎಂದು ಹೇಳಿದಲ್ಲಿ, ಯಾಕೆ?
27	ಬೇಡ ಎಂದು ಹೇಳಿದಲ್ಲಿ, ಯಾಕೆ ?
28	ಶಾಲೆಯಲ್ಲಿ ಮಧ್ಯಾಹ್ನದ ಊಟದ ವ್ಯವಸ್ಥೆ ಬಗ್ಗೆ ನಿಮ್ಮ ಸಲಹೆಗಳೇನಾದರೂ ಇದ್ದಲ್ಲಿ ದಯಮಾಡಿ ಹೇಳಿ.

ಪರಿಶೋಧಕರ ಪರಿವೀಕ್ಷಣೆ

ಮಧ್ಯಾಹ್ನದ ಬಿಸಿ ಊಟದ ಸರ್ವೆ–2003 ಭಾಗ–6 – ಪರಿಶೋಧಕರ ಪರಿವೀಕ್ಷಣೆ	
ದಿನಾಂಕ	
ಪರಿಶೋಧಕರ ಹೆಸರು	
ಹಳ್ಳಿಯ ಹೆಸರು	
ಶಾಲೆಯ ಹೆಸರು	
ಪಂಚಾಯತ್	
ತಾಲೂಕ	
ಜಿಲ್ಲೆ	
ರಾಜ್ಯ	

1. ಹಳ್ಳಿಯಲ್ಲಿ ಮಧ್ಯಾಹ್ನದ ಬಿಸಿ ಊಟ ಕಾರ್ಯಕ್ರಮ ನಡೆಯುತ್ತಿರುವದರ ಬಗ್ಗೆ ನಿಮ್ಮ ಅನಿಸಿಕೆಯೇನು?

2. ಧಾನ್ಯಗಳ ಸರಬರಾಜು, ದಾಸ್ತಾನು, ಮತ್ತು ದಾಖಲೆಗಳ ನಿರ್ವಹಣೆಯ ಬಗ್ಗೆ ನಿಮ್ಮಅನಿಸಿಕೆಯೇನು?

3. ಮಧ್ಯಾಹ್ನದ ಊಟದ ಮೇಲ್ವಿಚಾರಣೆ ಮತ್ತು ಮೌಲ್ಯಮಾಪನ ಎಷ್ಟು ದಿವಸಕ್ಕೊಮ್ಮೆ ಹಳ್ಳಿಯಲ್ಲಿ ನಡೆಯುತ್ತದೆ?ಯಾರು ಮೇಲ್ವಿಚಾರಣೆ ಮಾಡುತ್ತಾರೆ?

4. ಹಳ್ಳಿಯಲ್ಲಿ ಶಿಕ್ಷಕರ ಮೇಲೆ ಮಧ್ಯಾಹ್ನದ ಉಪಹಾರವು ಯಾವ ರೀತಿ ಪರಿಣಾಮ ಬೀರಿ ಅವರ ಪಾತ್ರದ ಮೇಲೆ ಪ್ರಭಾವ ಬೀರಿದೆ?

5. ಮಧ್ಯಾಹ್ನದ ಊಟ ಬಡಿಸುವದರಲ್ಲಿ ಜಾತಿ ತಾರತಮ್ಯ ಕಂಡು ಬಂದಿದೆಯೇ?

6. ಮಕ್ಕಳ ಮೇಲೆ ಮಧ್ಯಾಹ್ನದ ಬಿಸಿ ಊಟ ಯೋಜನೆ ಪರಿಣಾಮ ಬೀರುವದರ ಬಗ್ಗೆ ನಿಮ್ಮ ಅನಿಸಿಕೆಯೇನು?

7. ಮಧ್ಯಾಹ್ನದ ಬಿಸಿ ಊಟ ಯೋಜನೆಯ ಬಗ್ಗೆ ಪಾಲಕರು ತೋರಿಸುವ ಪ್ರತಿಕ್ರಿಯೆಯ ಬಗ್ಗೆ ನಿಮ್ಮ ಅನಿಸಿಕೆಯೇನು?ಇದು ಉಪಯೋಗಕರ ಎಂದು ಅವರು ಯೋಚಿಸುತ್ತಿದ್ದಾರೆಯೇ?

ಮಧ್ಯಾಹ್ನದ ಊಟ ಕುರಿತು ಸರ್ವೇಕ್ಷಣೆ – 2003

Mid Day Meal Survey - 2003

ಭಾಗ 2 : 'ಜಿಲ್ಲಾ ಮಟ್ಟದ ಪ್ರಶ್ನಾವಳಿ

PART 2: "DISTRICT LEVEL" QUESTIONNAIRE

ದಿನಾಂಕ : _____ ಮಾಹಿತಿ ಸಂಗ್ರಹಿಸುವವರ ಹೆಸರು : _____

DATE **NAME OF THE INVESTIGATOR**

- ಜಿಲ್ಲೆಯ ಹೆಸರು (NAME OF THE DISTRICT) : ----------
- ಕರ್ನಾಟಕ ರಾಜ್ಯ **Karnataka State**

I. ಸಾಮಾನ್ಯ ವಿವರಗಳು GENERAL INFORMATION

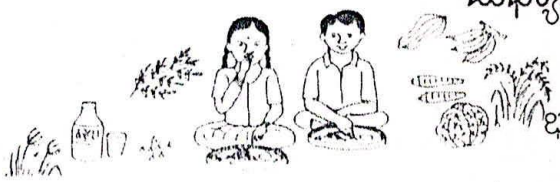
1.	ಅಧಿಕಾರಿಗಳ ಹೆಸರು		
2.	ಹುದ್ದೆ		
3	ನಿಮ್ಮ ಜಿಲ್ಲೆಯಲ್ಲಿ ಮಧ್ಯಾಹ್ನದ ಊಟ ಯೋಜನೆ ಯಾವಾಗ ಆರಂಭವಾಯಿತು	ತಿಂಗಳು	
		ವರ್ಷ	
4	ನಿಮ್ಮ ಜಿಲ್ಲೆಯಲ್ಲಿ ಒಟ್ಟು ಎಷ್ಟು ಘಟಕಗಳಿವೆ (blocks)?		
4.a	ನಿಮ್ಮ ಜಿಲ್ಲೆಯ ಎಷ್ಟು ಬ್ಲಾಕ್‌ಗಳಲ್ಲಿ ಮಧ್ಯಾಹ್ನ ಬಿಸಿ ಊಟ ನೀಡುತ್ತಿದ್ದಾರೆ?		
b.	ನಿಮ್ಮ ಜಿಲ್ಲೆಯಲ್ಲಿ ಎಷ್ಟು ಪ್ರಾಥಮಿಕ ಶಾಲೆಗಳಿವೆ?		
c.	ನಿಮ್ಮ ಜಿಲ್ಲೆಯ ಎಷ್ಟು ಪ್ರಾಥಮಿಕ ಶಾಲೆಗಳಲ್ಲಿ ಮಧ್ಯಾಹ್ನ ಬಿಸಿ ಊಟ ನೀಡುತ್ತಿದ್ದಾರೆ?		
d.	ನಿಮ್ಮ ಜಿಲ್ಲೆಯಲ್ಲಿ ಮಧ್ಯಾಹ್ನದ ಊಟ ಯೋಜನೆಯಡಿ ಒಟ್ಟು ಎಷ್ಟು ಮಕ್ಕಳಿದ್ದಾರೆ?'		
5	ಮಧ್ಯಾಹ್ನದ ಊಟ ಯೋಜನೆಯಡಿ ಬರುವ ಶಾಲೆಗಳಲ್ಲಿ ಈ ಮುಂದಿನ ಶಾಲೆಗಳು ಎಷ್ಟಿವೆ?		
	1) ಸರ್ಕಾರೀ ಶಾಳೆಗಳು	:	
	2) ರಾಜೀವ್ ಗಾಂಧಿ ಪಾಠಶಾಲೆಗಳು	:	
	3) ಶಿಕ್ಷಾ ಕರ್ಮೀ ಶಾಲೆಗಳು	:	
	4) ಸರ್ಕಾರದ ಅನುದಾನ ಪಡೆಯುವ ಶಾಲೆಗಳು	:	
	5) ಪಚಿರ್ಯಾಯ ಶಾಲೆಗಳು	:	
	6) ಇತರ ಶಾಲೆಗಳು	:	
6	ಭಾರತ ಆಹಾರ ನಿಗಮ (ಎಫ್.ಸಿ.ಐ.)ದ ಗೋದಾಮಿನಿಂದ ಧಾನ್ಯವನ್ನು ಶಾಲೆಗಳಿಗೆ ಹೇಗೆ ಸರಬರಾಜು ಮಾಡಲಾಗುತ್ತದೆ?		

6 7	ನಿಮ್ಮ ಜಿಲ್ಲೆಯ ಎಲ್ಲ ಶಾಲೆಗಳಿಗಾಗಿ ತಿಂಗಳೊಂದಕ್ಕೆ ನಿಗಧಿಪಡಿಸಲಾಗಿ ಆಹಾರ ಧಾನ್ಯಗಳ ಒಟ್ಟು ಪ್ರಮಾಣವೆಷ್ಟು?	
8	ಮಧ್ಯಾಹ್ನದ ಊಟ ಯೋಜನೆಯನ್ನು ಆರಂಭಿಸಲಾಗಿರುವ ಎಲ್ಲ ಶಾಲೆಗಳ ಎಲ್ಲ ಮಕ್ಕಳಿಗೆ ಇಷ್ಟು ಪ್ರಮಾಣದ ಆಹಾರಧಾನ್ಯಗಳು ಸಾಕಾಗುತ್ತದೆಯೆ?	
	1. ಸಾಕಾಗುತ್ತದೆ	
	2. ಸಾಕಾಗುವುದಿಲ್ಲ	
	3. ಉತ್ತರವಿಲ್ಲ (?)ಓಖ	
8.9	ಉತ್ತರ ಇಲ್ಲ ಎಂದಾದಲ್ಲಿ, ಪ್ರತಿ ತಿಂಗಳಿಗೆ ನಿಮಗೆಷ್ಟು ಪ್ರಮಾಣದಲ್ಲಿ ಧಾನ್ಯ ಬೇಕಾಗುತ್ತದೆ?	
910	ನಿಮ್ಮ ಜಿಲ್ಲೆಯಲ್ಲಿ ಮಧ್ಯಾಹ್ನದ ಊಟ ಒದಗಿಸಲು ನಿಮಗೆ ಈ ಮುಂದಿನವುಗಳಿಗೆ ಬರುವ ಖರ್ಚುಗಳೆಷ್ಟು?	
	1) ಧಾನ್ಯ (ಕಾಳು)	
	2) ಬೇಳೆ ಮತ್ತಿತರ ಅಡುಗೆ ಸಾಮಾನುಗಳು	
	3) ಉರುವಲು	
	4) ಸಂಬಳ	
	5) ಕಬ್ಬಿಣಾಂಶದ ಗುಳಿಗೆಗಳು (ನೀಡುತ್ತಿದ್ದಲ್ಲಿ)	
	6) ಶಾಲೆಗೆ ತಲುಪಿಸಲು ಸಾರಿಗೆ	
10	ಈ ಮೇಲಿನ ಖರ್ಚುಗಳನ್ನು ಯಾವ ಇಲಾಖೆ / ಇಲಾಖೆಗಳು ಭರಿಸತ್ತವೆ?	
12	ಮಧ್ಯಾಹ್ನದ ಊಟದ ವ್ಯವಸ್ಥೆ ಮಾಡಲು ಒಮ್ಮೆ ಮಾತ್ರ ಖರ್ಚುಮಾಡಬೇಕಾದ ಸಾಧನಗಳ ಅಂದಾಜು ಎಷ್ಟು?	
	1) ಅಡುಗೆ ಮನೆಯ ನಿರ್ಮಾಣ	
	2) ಪಾತ್ರೆಗಳು	
	3) ಗ್ಯಾಸ್ ಒಲೆ (ಬೇಕಿದ್ದಲ್ಲಿ / ಇದ್ದಲ್ಲಿ)	
	4) ನೀರಿಗಾಗಿ ತೊಟ್ಟಿ (ಟ್ಯಾಂಕ್)	
	5) ಇತರೆ	
13	ಈ ಮೇಲಿನ ಖರ್ಚುಗಳನ್ನು ಯಾವ ಇಲಾಖೆ ಭರಿಸುತ್ತದೆ ?	
14	ಮಧ್ಯಾಹ್ನದ ಊಟ ಒದಗಿಸಲು ಪ್ರತಿ ಮಗುವಿಗೆ ಬರುವ ಖರ್ಚು ಎಷ್ಟು ?	ರೂ.
15	ಯಾವುದಾದರೂ ಯೋಜನೆಯಡಿ ಕುಡಿಯುವ ನೀರಿನ ಸರಬರಾಜು ಆತವೆಯೆ?	1) ಹೌದು
		2) ಇಲ್ಲ
		3) ಉತ್ತರವಿಲ್ಲ NR
16	ಉತ್ತರ ಹೌದಾದಲ್ಲಿ, ಯಾವ ಯೋಜನೆಯಡಿ?	
17	ಜಿಲ್ಲಾ ಮಟ್ಟದಲ್ಲಿ ಮಧ್ಯಾಹ್ನದ ಊಟ ನೀಡುವ ಯೋಜನೆಯಲ್ಲಿ ನಿಮ್ಮ ನಿರ್ದಿಷ್ಟ ಪಾತ್ರವೇನು?	

18	ರಾಜ್ಯ ಸರ್ಕಾರದೊಡನೆ ನೀವು ಹೇಗೆ ಸಂಯೋಜನೆ ಮಾಡುತ್ತೀರಿ (ಧಾನ್ಯ ಮತ್ತು ಹಣ ಪಡೆಯುವುದು, ಇತ್ಯಾದಿ)? ವಿವರಿಸಿ	
19	ಘಟಕಗಳೊಡನೆ ನೀವು ಹೇಗೆ ಸಂಯೋಜಿಸುತ್ತೀರಿ? ವಿವರಿಸಿ	
20	ಮಧ್ಯಾಹ್ನದ ಊಟ ಯೋಜನೆಗಾಗಿ ನಿರ್ದಿಷ್ಟ ಅಧಿಕಾರಿಯಿದ್ದಾರೇನು? ಯಾರು ಆ ಅಧಿಕಾರಿಗಳು?	
21	ಮಧ್ಯಾಹ್ನದ ಊಟ ಯೋಜನೆಗಾಗಿ ನೀವು ಯಾವ ಯಾವ ಇಲಾಖೆಗಳೊಡನೆ ಸಂಯೋಜಿಸಬೇಕಾಗುತ್ತದೆ?	
	1) ರಾಜ್ಯ ಮಟ್ಟದಲ್ಲಿ	
	2) ಘಟಕದ ಮಟ್ಟದಲ್ಲಿ	
22	ಮಧ್ಯಾಹ್ನದ ಊಟ ಯೋಜನೆಯನ್ನು ನಿರ್ವಹಿಸಲು ನಿಮಗೆದುರಾಗುವ ಸಮಸ್ಯೆಗಳು ಯಾವುವು?	
	1) ಆಹಾರ ಧಾನ್ಯಗಳನ್ನು ಪಡೆಯುವುದು	
	2) ಮಧ್ಯಾಹ್ನದ ಊಟ ನೀಡಲು ಘಟಕಗಳಿಗೆ ಹಣ ವಿತರಿಸುವುದು	
	3) ಧಾನ್ಯಗಳು ಮತ್ತು ಬೇಳೆಗಳನ್ನು ವಿತರಿಸುವುದು	
	4) ಎಫ್.ಸಿ.ಐ.ನಿಂದ ಸಾಗಿಸುವುದು	
	5) ಇತರೆ	
23	ನಿಮ್ಮ ಅಭಿಪ್ರಾಯದಂತೆ ಮಧ್ಯಾಹ್ನದ ಊಟ ಯೋಜನೆ ಹೇಗೆ ನಡೆದಿದೆ?	1) ಬಹಳ ಚೆನ್ನಾಗಿದೆ 2) ಚೆನ್ನಾಗಿದೆ 3) ಪರವಾಗಿಲ್ಲ 4) ಕೆಟ್ಟದಾಗಿದೆ
24	ಮಧ್ಯಾಹ್ನದ ಊಟ ಯೋಜನೆ ಕುರಿತಂತೆ ಏನಾದರೂ ನಿರ್ದಿಷ್ಟ ಸೂಚನೆಗಳು ಮತ್ತು ಟೀಕೆಗಳು ಇದೆಯೇನು?	

ಮಧ್ಯಾಹ್ನದ ಊಟ ಕುರಿತು ಸರ್ವೇಕ್ಷಣೆ – 2003

Mid Day Meal Survey - 2003



ಭಾಗ 4 : 'ಅಧ್ಯಾಪಕ ವರ್ಗದವರಿಗಾಗಿ ಪ್ರಶ್ನಾವಳಿ'

PART4: "TEACHER" QUESTIONNAIRE

ದಿನಾಂಕ : _____ ಮಾಹಿತಿ ಸಂಗ್ರಹಿಸುವವರ ಹೆಸರು : _____
DATE NAME OF THE INVESTIGATOR

ದಿನಾಂಕ : _____ ಮಾಹಿತಿ ಸಂಗ್ರಹಿಸುವವರ ಹೆಸರು : _____
DATE NAME OF THE INVESTIGATOR

ದಿನಾಂಕ : _____ ಮಾಹಿತಿ ಸಂಗ್ರಹಿಸುವವರ ಹೆಸರು : _____
DATE NAME OF THE INVESTIGATOR

ಹಳ್ಳಿಯ ಹೆಸರು	
ಪಂಚಾಯಿತಿ	
ಘಟಕ (ಬ್ಲಾಕ್)	
ಜಿಲ್ಲೆ	
ರಾಜ್ಯ	ಕರ್ನಾಟಕ

I. ಸಾಮಾನ್ಯ ವಿವರಗಳು GENERAL INFORMATION				
ಕ್ರಮ ಸಂಖ್ಯೆ	ಪ್ರಶ್ನೆ	ಆಯ್ಕೆ ಸಂಖ್ಯೆ	ಆಯ್ಕೆಗಾಗಿ ವಿಚಾರಗಳು	ಆಯ್ಕೆ
1.	ಶಾಲೆಯ ಹೆಸರು			
2	ಇದು ಎಂತಹ ಶಾಲೆ?	1	ಸರ್ಕಾರಿ ಪ್ರಾಥಮಿಕ ಶಾಲೆ	
		2	ರಾಜೀವ್ ಗಾಂಧಿ ಪಾಠಶಾಲೆ	
		3	ಶಿಕ್ಷಾ ಕರ್ಮಿ ಶಾಲೆ	
		4	ಇತರೆ (ವಿವರಿಸಿ)	
		5	NR	
II. ಶಾಲೆಯಲ್ಲಿರುವ ಸೌಲಭ್ಯಗಳು . SCHOOL INFRASTRUCTURE				
3	ಇರುವ ಒಟ್ಟು ತರಗತಿ ಕೋಣೆಗಳು	1	ಇಲ್ಲ	
		2	ಒಂದು	
		3	ಎರಡು	
		4	ಮೂರು	
		5	ಇತರೆ (ವಿವರಿಸಿ)	
		6	NR	
4	ಒಟ್ಟು ಶಿಕ್ಷಕರ ಸಂಖ್ಯೆ	1	ಒಬ್ಬರು	
		2	ಇಬ್ಬರು	
		3	ಮೂರು	
		4	ಇತರೆ	
		5	NR	

5	ಶಾಲೆಯ ಆವರಣದಲ್ಲಿ ಸುಸ್ಥಿತಿಯಲ್ಲಿರುವ ಶೌಚಾಲಯವಿದೆಯೆ?	(1)	ಹೌದು	
		(2)	ಇಲ್ಲ	
		(3)	ಉತ್ತರವಿಲ್ಲ NR	
6	ಮಧ್ಯಾಹ್ನದ ಊಟ ಯೋಜನೆಗಾಗಿ ಅಡುಗೆ ಮನೆ ವ್ಯವಸ್ಥೆ ಇದೆಯೆ?	1	ನಿರ್ಮಾಣವಾಗಿರುವ ಅಡುಗೆಮನೆ	
		2	ತಾತ್ಕಾಲಿಕ ಶೆಡ್	
		3	ಕೇಂದ್ರ ಅಡುಗೆ ಮನೆ	
		4	ಅಡುಗೆಯವರ ಮನೆ	
		5	ಅಡುಗೆ ಮನೆಯೇ ಇಲ್ಲ	
		6	NR	

III. ಮಧ್ಯಾಹ್ನದ ಊಟ ಯೋಜನೆ MID DAY MEAL PROGRAM

7	ಶಾಲೆಯಲ್ಲಿ ಬಿಸಿ ಊಟ ಯೋಜನೆಯಡಿ ಊಟ ನೀಡಲಾಗುತ್ತಿದೆಯೆ?	(1)	ಹೌದು	
		(2)	ಇಲ್ಲ	
		(3)	ಉತ್ತರವಿಲ್ಲ NR	
8	ಇಲ್ಲ ಎಚೆದಾದಲ್ಲಿ, ಈ ಮುಂದಿನವುಗಳಲ್ಲಿ ಯಾವುದನ್ನಾದರೂ ನೀಡಲಾಗುತ್ತಿದೆಯೆ?	1	ಅಕ್ಕಿ, ಬೇಳೆ ಇತ್ಯಾದಿ	
		2	ಮೊದಲೇ ಬೇಯಿಸಿದ ಅಥವಾ ತಿನ್ನಲು ಸಿದ್ಧವಾದ ಆಹಾರ	
		3	ಇನ್ಯಾವುದಾದರೂ ರೀತಿಯ ಮಧ್ಯಾಹ್ನದ ಊಟ	
		4	ಈ ಯಾವುವೂ ಇಲ್ಲ	
		5	NR	
9	ಪ್ರತಿದಿನವೂ ಒಂದೇ ರೀತಿಯ ಊಟವೆ?	(1)	ಹೌದು	
		(2)	ಇಲ್ಲ	
		(3)	ಉತ್ತರವಿಲ್ಲ NR	
10	ಇಲ್ಲ ಎಂದಾದಲ್ಲಿ, ಬೇರೆ ಏನು ನೀಡಲಾಗುತ್ತದೆ. ವಿವರಿಸಿ			
11	ಆಹಾರದ ರೀತಿಯನ್ನು (menu) ಯಾರು ನಿರ್ಧರಿಸುತ್ತಾರೆ (ಹೆಚ್ಚು ಉತ್ತರಗಳು ಇರಬಹುದು)	1	ಜಿಲ್ಲಾ ಶಿಕ್ಷಣ ಇಲಾಖೆಯಂತೆ	
		2	ಶಾಲಾ ಸಮಿತಿ ಹೇಳಿದಂತೆ	
		3	ಮುಖ್ಯೋಪಾಧ್ಯಾಯರು	
		4	ಇತರೆ (ವಿವರಿಸಿ)	
		5	NR	

12	ಮಧ್ಯಾಹ್ನ ಊಟ ಯೋಜನೆಗಾಗಿ ನೀಡಲಾಗಿ ಧಾನ್ಯ /ಕಾಳಿನ ಗುಣಮಟ್ಟದ ಬಗ್ಗೆ ನೀವೇನು ಹೇಳುತ್ತೀರಿ?	1	ಬಹಳ ಉತ್ತಮ	
		2	ಉತ್ತಮ	
		3	ಸರಾಸರಿ	
		4	ಚೆನ್ನಾಗಿಲ್ಲ	
		5	ಕೆಟ್ಟದಾಗಿದೆ	
		6	NR	
13	ಅಡುಗೆ ಯಾರು ಮಾಡುತ್ತಾರೆ? (ಹಲವಾರು ಸಾಧ್ಯತೆಗಳು)	1	ಅಡುಗೆಯವರು	
		2	ಶಿಕ್ಷಕ ವರ್ಗ	
		3	ವಿಧ್ಯಾರ್ಥಿಗಳು	
		4	ಇತರೆ (ವಿವರಿಸಿ)	
		5	NR	
14	ಅಡುಗೆಯವರನ್ನು ಯಾರು ನೇಮಿಸಿಕೊಂಡರ	1	ಸರ್ಕಾರ	
		2	ಗ್ರಾಮ ಪಂಚಾಯಿತಿ	
		3	ಶಿಕ್ಷಕರು	
		4	ಇತರೆ (ವಿವರಿಸಿ)	
		5	ಪ್ರಶ್ನೆಯ ಅವಶ್ಯಕತೆ ಇಲ್ಲ	
		6	NR	
15	ಅಡುಗೆಯವರನ್ನು ಹೇಗೆ ಆಯ್ಕೆ ಮಾಡಲಾಯಿತು . ದಯಮಾಡಿ ವಿವರಿಸಿ.			
16	ಮಧ್ಯಾಹ್ನದ ಊಟ ಯೋಜನೆ ತರಗತಿಗಳು ನಡೆಯಲು ತೊಂದರೆ ತಂದಿದೆಯೆಂದು ನಿಮಗನ್ನಿಸುತ್ತದೆಯೆ?	(1)	ಹೌದು	
		(2)	ಇಲ್ಲ	
		(3)	ಉತ್ತರವಿಲ್ಲ NR	
17	ಹೌದು ಎಂದಲ್ಲಿ, ಯಾಕೆ ಮತ್ತು ಹೇಗೆ – ವಿವರಿಸಿ			
IV. ದಿವಸ ಧಾನ್ಯದ ಗುಣಮಟ್ಟ **QUANTITY OF GRAIN**				
18	ಮಧ್ಯಾಹ್ನದ ಊಟ ಯೋಜನೆಯಡಿ ಈ ಶಾಲೆಗೆ ಪ್ರತಿತಿಂಗಳಿಗೆ ನಿಗಧಿ ಪಡಿಸಲಾಗಿರುವ ಧಾನ್ಯದ ಒಟ್ಟು ಪ್ರಮಾಣವೆಷ್ಟು?			

19	ಸಾಮಾನ್ಯವಾಗಿ ನಿಮಗೆ ಬರುವ ಧಾನ್ಯದ ಗುಣಮಟ್ಟ ಹೇಗಿರುತ್ತದೆ?			
20	ಅಕಸ್ಮಾತ್ ಬಂದ ಧಾನ್ಯದಲ್ಲಿ ಕೊರತೆಯಾದರೆ ಏನು ಮಾಡುತ್ತೀರಿ?	1	ವಾರದಲ್ಲಿ ಕೆಲವು ದಿನಗಳು ಮಾತ್ರಾ ಊಟ ನೀಡಲಾಗುವುದು	☐
		2	ಪ್ರತಿ ಮಗುವಿಗೆ ನೀಡುವ ಪ್ರಮಾಣ ಕಡಿಮೆ ಮಾಡುವುದು	☐
		3	ದಾಸ್ತಾನು ಇರುವವರೆಗೆ ಮಾತ್ರಾ ಊಟ ಕೊಡುವುದು	☐
		4	ಪ್ರಸ್ತುತವಲ್ಲ	☐
		5	ಇತರೆ (ವಿವರಿಸಿ)	☐
		6	NR	☐
V. ವ್ಯವಸ್ಥೆಗಳು : LOGISTICS AND INFRASTRUCTURE				
21	ಸಾಮಾನ್ಯವಾಗಿ ಆಹಾರ ಧಾನ್ಯವು ಸರಿಯಾದ ಸಮಯಕ್ಕೆ ಶಾಲೆಗೆ ತಲುಮತ್ತದೆಯೆ?	(1)	ಹೌದು	☐
		(2)	ಇಲ್ಲ	
		(3)	ಉತ್ತರವಿಲ್ಲ NR	
22	ಆಹಾರ ಧಾನ್ಯಗಳು ಹಾಗೂ ಇತರ ವಸ್ತುಗಳನ್ನು ಪಡೆಯಲು ಏನಾದರೂ ನಿರ್ದಿಷ್ಟ ಸಮಸ್ಯೆಗಳು ಇದೆಯೇನು. ವಿವರಿಸಿ			
23	ಆಹಾರ ಧಾನ್ಯಗಳನ್ನು ಎಲ್ಲಿ ದಾಸ್ತಾನು ಮಾಡಲಾಗುವುದು	1	ಶಾಲೆ	☐
		2	ಸರಪಂಚರ ಮನೆ	
		3	ನ್ಯಾಯಬೆಲೆ ಅಂಗಡಿ	☐
		4	ಅಡುಗೆಯವರ ಮನೆ	
		5	ಶಿಕ್ಷಕರ ಮನೆ	☐
		6	ಇತರೆ (ವಿವರಿಸಿ)	☐
		7	NR	
				☐
24	ಇರುವ ವಸ್ತುಗಳನ್ನು ಕುರಿತು ಏನಾದರೂ ವ್ಯವಸ್ಥಿತ ದಾಖಲೆ ಇದೆಯೇನು?	(1)	ಹೌದು	☐
		(2)	ಇಲ್ಲ	
		(3)	ಉತ್ತರವಿಲ್ಲ NR	
25	ಹೌದು ಎಂದಾದರೆ ಯಾರು ಈ ದಾಖಲೆ ಇಡುತ್ತಾರೆ?			

VI. ಮಧ್ಯಾಹ್ನದ ಊಟದ ಖರ್ಚುಗಳು COSTS OF MDM

26	ಈ ಯೋಜನೆಯ ಖರ್ಚುಗಳೆಷ್ಟು?				
	ಸದಾ ಆಗುವ ಖರ್ಚುಗಳು (ತಿಂಗಳಿಗೆ)				
	1	ಧಾನ್ಯ ಕಾಳುಗಳು			
	2	ಬೇಳೆ			
	3	ಎಣ್ಣೆ			
	4	ಸಾಂಬಾರು ಪದಾರ್ಥಗಳು			
	5	ಉರುವಲು			
	6	ಸಂಬಳ			
	ವಸ್ತುಗಳು (ಒಮ್ಮೆ ಮಾತ್ರಾ ಮಾಡುವುದು)				
	1	ಅಡುಗೆ ಕೋಣೆ ನಿರ್ಮಾಣ			
	2	ಪಾತ್ರೆಗಳು			
	3	ತಕ್ಕಡಿ			
	4	ಗ್ಯಾಸ್ ಒಲೆ			
	5	ನೀರಿನ ತೊಟ್ಟಿ			

VII. ಉಸ್ತುವಾರಿ ಮತ್ತು ಮೌಲ್ಯಮಾಪನ MONITORING AND EVALUATION

27	ಈ ಶೈಕ್ಷಣಿಕ ವರ್ಷದ ಆರಂಭದಿಂದ ಸರ್ಕಾರದ ಅಧಿಕಾರಿಗಳಿಂದ ಭೇಟಿ ಮತ್ತು ಪರಿಶೀಲನೆ ನಡೆದಿದೆಯೆ?	(1)	ಹೌದು	☐
		(2)	ಇಲ್ಲ	
		(3)	ಉತ್ತರವಿಲ್ಲ NR	

28	ಶಾಲಾ ಮಟ್ಟದಲ್ಲಿ ಮಧ್ಯಾಹ್ನದ ಊಟವನ್ನು ಯಾರು ಉಸ್ತುವಾರಿ ಮಾಡುತ್ತಾರೆ? (ಹಲವು ಉತ್ತರಗಳ ಸಾಧ್ಯತೆ)	1	ಗ್ರಾಮ ಪಂಚಾಯಿತಿ	☐
		2	ಶಿಕ್ಷಕ–ಪೋಷಕ ಸಮಿತಿ	☐
		3	ಪೋಷಕರ ಪ್ರತಿನಿಧಿಗಳು	☐
		4	ಶಿಕ್ಷಕರು	☐
		5	ಇತರೆ (ವಿವರಿಸಿ)	☐
		6	NR	☐

29	ಕಳೆದ ವರ್ಷಕ್ಕೆ ಹೋಲಿಸಿದರೆ ಈ ವರ್ಷ ಶಾಲೆಗೆ ದಾಖಲಾದ ವಿದ್ಯಾರ್ಥಿಗಳ ಸಂಖ್ಯೆಯಲ್ಲಿ ಹೆಚ್ಚಾಗಿದೆ ಎಂದು ನಿಮಗೆ ಅನ್ನಿಸ್ಯತ್ತದೆಯೆ?	1	ಹೌದು	☐
		2	ಇಲ್ಲ	
		3	ಹೇಳಲಾಗದು	
		4	NR	

30	ಹೌದು ಎಂದರೆ, ಎಷ್ಟು ಹೆಚ್ಚಾಗಿದೆ – ಸರಾಸರಿ	1	ಶೇ.10ಕ್ಕಿಂತಾ ಕಡಿಮೆ	
		2	ಶೇ.10 ರಿಂದ 20ರೊಳಗೆ	
		3	ಶೇ.20 ರಿಂದ 30 ರೊಳಗೆ	
		4	ಶೇ. 30 ರಿಂದ 40 ರೊಳಗೆ	
		5	ಶೇ. 40 ರಿಂದ 50 ರೊಳಗೆ	
		6	ಶೇ. 50ಕ್ಕಿಂತಾ ಹೆಚ್ಚು (ಸ್ಪಷ್ಟ ಮಾಡಿ)	
		7	NR	
31	ಕಳೆದ ವರ್ಷಕ್ಕೆ ಹೋಲಿಸಿದರೆ, ಈ ವರ್ಷ ಹೆಚ್ಚಿನ ಸಂಖ್ಯೆಯಲ್ಲಿ ಹೆಣ್ಣು ಮಕ್ಕಳು ಶಾಲೆಗೆ ದಾಖಲಾಗಿದ್ದಾರೆಂದು ನಿಮಗನ್ನಿಸುತ್ತದೆಯೆ?	1	ಹೌದು	
		2	ಇಲ್ಲ	
		3	ಹೇಳಲಾಗದು	
		4	NR	
32	ಹೌದು ಎಂದರೆ, ಎಷ್ಟು ಹೆಚ್ಚಾಗಿದೆ – ಸರಾಸರಿ	1	ಶೇ.10ಕ್ಕಿಂತಾ ಕಡಿಮೆ	
		2	ಶೇ.10 ರಿಂದ 20ರೊಳಗೆ	
		3	ಶೇ.20 ರಿಂದ 30 ರೊಳಗೆ	
		4	ಶೇ. 30 ರಿಂದ 40 ರೊಳಗೆ	
		5	ಶೇ. 40 ರಿಂದ 50 ರೊಳಗೆ	
		6	ಶೇ. 50ಕ್ಕಿಂತಾ ಹೆಚ್ಚು (ಸ್ಪಷ್ಟ ಮಾಡಿ)	
		7	NR	
33	ಕಳೆದ ವರ್ಷಕ್ಕೆ ಹೋಲಿಸಿದರೆ ಈವರ್ಷ ವಿಧ್ಯಾರ್ಥಿಗಳು ಹಾಜರಿ ತಪ್ಪಿಸುವುದು ಕಡಿಮೆಯಾಗಿದೆಯೇನು?	1	ಹೌದು	
		2	ಇಲ್ಲ	
		3	NR	
34	ಹೌದು ಎಂದರೆ, ಅಂದಾಜು ಎಷ್ಟು ಕಡಿಮೆಯಾಗಿದೆ?			
35	ಮಧ್ಯಾಹ್ನದ ಊಟ ಆರಂಭವಾದ ಮೇಲೆ ಪಾಠ ಪ್ರವಚನಗಳಲ್ಲಿ ಮಕ್ಕಳ ಆಸಕ್ತಿಯ ಮಟ್ಟವನ್ನು ನೀವು ಹೇಗೆ ಗುರುತಿಸುವಿರಿ	1	ಹೆಚ್ಚು ಆಸಕ್ತಿ ಬಂದಿದೆ	
		2	ಮೊದಲಿದ್ದಂತೆಯೇ	
		3	ಆಸಕ್ತಿ ಕಡಿಮೆಯಾಗಿದೆ	
		4	ಹೇಳಲಾಗದು	
		5	NR	
36	ಮಧ್ಯಾಹ್ನದ ಊಟವನ್ನು ಎಷ್ಟು ಘಂಟೆಗೆ ಕೊಡಲಾಗುವುದು?			

37	ಮಧ್ಯಾಹ್ನದ ಊಟ ನೀಡುವುದರಿಂದ ಮಧ್ಯಾಹ್ನದ ಶಾಲಾ ಅವಧಿಯಲ್ಲಿ ಮಕ್ಕಳ ಹಾಜರಾತಿ ಸಂಖ್ಯೆ ಹೆಚ್ಚಿಸುವುದೋ ಅಥವಾ ಕಡಿಮೆ ಮಾಡುವುದೋ?			
38	ಯಾಕೆ ? ವಿವರಿಸಿ ಭ್ರಾತಿ ಭೇದಭಾವ			
39	ಮಕ್ಕಳು ಊಟಕ್ಕೆ ಸಾಮಾನ್ಯವಾಗಿ ಹೇಗೆ ಕುಳಿತುಕೊಳ್ಳುತ್ತಾರೆ? (ಬಹು ಉತ್ತರಗಳು)	1	ಹುಡುಗರು – ಹುಡುಗಿಯರು ಪ್ರತ್ಯೇಕವಾಗಿ	☐
		2	ಬೇರೆ ಬೇರೆ ತರಗತಿಯ ಮಕ್ಕಳು ಪ್ರತ್ಯೇಕವಾಗಿ	
		3	ಬೇರೆ ಬೇರೆ ಜಾತಿಯ ಮಕ್ಕಳು ಪ್ರತ್ಯೇಕವಾಗಿ	☐
		4	ಎಲ್ಲ ಮಕ್ಕಳು ಜೊತೆಯಾಗಿ	☐
		5	ಇತರೆ (ವಿವರಿಸಿ)	☐
		6	ಉತ್ತರವಿಲ್ಲ NR	☐

40	ಮೇಲ್ವರ್ಗ/ಜಾತಿಯ ಪೋಷಕರು, ತಮ್ಮ ಮಕ್ಕಳು ಕೆಳ ಜಾತಿಯ ಮಕ್ಕಳೊಡನೆ ಕುಳಿತು ಊಟ ಮಾಡುವುದಕ್ಕೆ ಯಾವಾಗಲಾದರೂ ವಿರೋಧಿಸಿದ್ದಾರೇನು?	1	ಹೌದು	☐
		2	ಇಲ್ಲ	
		3	NR	
41	ಹೌದು ಎಂದರೆ, ಈಗ ಈ ಸಮಸ್ಯೆ ಬಗೆಹರಿದಿದೆ ಎಚೆದು ನಿಮಗೆ ಅನಿಸುವುದೆ?	1	ಹೌದು	☐
		2	ಇಲ್ಲ	
		3	NR	
42.a	ಅದು ಬಗೆ ಹರಿದಿದೆ ಎಂದರೆ, ಹೇಗೆ ಆಯಿತು?	1	ಜಾತಿವಾರು ಪ್ರತ್ಯೇಕ ಕುಳಿತುಕೊಳ್ಳುವ/ ಊಟ ಮಾಡುವ ವ್ಯವಸ್ಥೆ ಮಾಡಲಾಗಿದೆ	☐
		2	ಕೆಳ ಜಾತಿಯ ಮಕ್ಕಳಿಗೆ ಊಟ ಹಾಕುವುದಿಲ್ಲ	
		3	ಮೇಲ್ಜಾತಿಯ ಮಕ್ಕಳು ಊಟ ಮಾಡುವುದಿಲ್ಲ	
		4	ಬೇರೆ ಬೇರೆ ಜಾತಿಯವರಿಗೆ ಬೇರೆ ಬೇರೆ ಅಡುಗೆ	
		5	ಇತರೆ (ವಿವರಿಸಿ)	
		6	NR	
42.b	ಸಮಸ್ಯೆ ಇನ್ನೂ ಇತ್ಯರ್ಥವಾಗಿಲ್ಲದಿದ್ದರೆ, ಅದನ್ನು ಪರಿಹರಿಸಲಾಗಬಹುದೇನು?	1	ಹೌದು	☐
		2	ಇಲ್ಲ	
		3	NR	
42c	ಹೌದು ಎಂದರೆ, ಹೇಗೆ? (ವಿವರಿಸಿ)			

42d	ಇಲ್ಲ ಎಂದರೆ, ಯಾಕೆ? ವಿವರಿಸಿ			
42c	ಮೇಲ್ಜಾತಿಯ ಮಕ್ಕಳು ತಾವು ಇತರ ಜಾತಿಯ ಮಕ್ಕಳೊಂದಿಗೆ ಊಟ ಮಾಡುವುದಕ್ಕೆ ಬೇಸರ ವ್ಯಕ್ತ ಪಡಿಸುವರೇನು? ಸೌಲಭ್ಯಗಳು	1 2 3	ಹೌದು ಇಲ್ಲ NR	☐
43	ಮಧ್ಯಾಹ್ನದ ಊಟ ಮಾಡಲು ಮಕ್ಕಳು ತಟ್ಟೆ ಉಪಯೋಗಿಸುವರೇನು?	1 2 3	ಹೌದು ಇಲ್ಲ NR	☐
44	ತಟ್ಟೆಗಳಿಗಾಗಿ ಏನು ವ್ಯವಸ್ಥೆಮಾಡಲಾಗಿದೆ?	1 2 3 4 5	ಶಾಲೆಯವರೆ ತಟ್ಟೆ ಒದಗಿಸಿದ್ದಾರೆ ಇತರೆ (ಉದಾ: ಎಲೆ) ವ್ಯವಸ್ಥೆ ಶಾಲೆ ಮಾಡಿದೆ ಮನೆಯಿಂದ ತಟ್ಟೆ ಅಥವಾ ಎಲೆ ತೆಗೆದುಕೊಂಡುಹೋಗಬೇಕು ಮಕ್ಕಳೇ ಏನಾದರೊಂದು ತಾತ್ಕಾಲಿಕ ವ್ಯವಸ್ಥೆ ಮಾಡಿಕೊಳ್ಳುತ್ತಾರೆ (ಉದಾ: ಪುಸ್ತಕದಿಂದ ಕಾಗದ ಹರಿದು) ಇತರೆ	
45	ನೀರಿಗೇನು ವ್ಯವಸ್ಥೆ ಮಾಡಲಾಗಿದೆ	1 2 3 4 5 6	ಶಾಲಾ ಆವರಣದಲ್ಲಿ ನೀರಿನ ಮೂಲವಿದೆ (ಉದಾ: ನಲ್ಲಿ) ಹತ್ತಿರದಿಂದ ಮಡಿಕೆಯಲ್ಲಿ ತರಲಾಗುತ್ತದೆ. ನೀರಿರುವ ಕಡೆಗೆ ಮಕ್ಕಳೇ ಹೋಗುತ್ತಾರೆ ಇತರೆ (ವಿವರಿಸಿ) ಯಾವುದೇ ವ್ಯವಸ್ಥೆ ಇಲ್ಲ ಉತ್ತರವಿಲ್ಲ NR	☐
46a	ಶಾಲಾ ಆವರಣದಲ್ಲೇ ನೀರಿನ ವ್ಯವಸ್ಥೆ ಇದ್ದಲ್ಲಿ ಏನದು?	1 2 3 4 5 6	ಕೈ ಪಂಪು ಕೊಳಾಯಿ ಬಾವಿ ತೊಟ್ಟಿ ಇತರೆ (ವಿವರಿಸಿ) NR	☐

46b	ನೀರನ್ನು ಮಡಿಕೆ, ಬಕೆಟ್‌ನಲ್ಲಿ ತರುವುದಾದರೆ ಯಾರು ತರುತ್ತಾರೆ.	1	ಹಣಕೊಟ್ಟು ಇದಕ್ಕಾಗಿ ನೇಮಿಸಲಾಗಿದೆ	
		2	ಮಕ್ಕಳು	
		3	ಶಿಕ್ಷಕರು	
		4	ಇತರೆ (ವಿವರಿಸಿ)	
		5	NR	
46c	ಮಕ್ಕಳು ನೀರಿಗಾಗಿ ಹತ್ತಿರದಲ್ಲೇ ಹೋಗುತ್ತಾರೆ ಎಂದರೆ ಯಾವಾಗ ಹೋಗಲು ಬಿಡಲಾಗುವುದು?	1	ಯಾವಾಗ ಬೇಕಾದರೂ	
		2	ನಿರ್ದಿಷ್ಟ ಸಮಯದಲ್ಲಿ	
		3	ಊಟದ ಸಮಯದಲ್ಲಿ ಮಾತ್ರಾ	
		4	NR	
46d	ಕುಡಿಯುವ ನೀರಿನ ವ್ಯವಸ್ಥೆ ಪರವಾಗಿಲ್ಲ ಎಂದು ನಿಮಗನ್ನಿಸುವುದೇನು?	1	ಹೌದು	
		2	ಇಲ್ಲ	
		3	NR	
46 e	ಇಲ್ಲ ಎಂದರೆ, ಯಾಕೆ ಆಗಿಲ್ಲ	1	ನೀರು ಸುರಕ್ಷಿತವಲ್ಲ	
		2	ನೀರು ಬಹಳ ದೂರದಲ್ಲಿದೆ	
		3	ಇತರೆ (ವಿವರಿಸಿ)	
		4	NR	
47	ಈ ಶೈಕ್ಷಣಿಕ ವರ್ಷದಲ್ಲಿ ಮಧ್ಯಾಹ್ನದ ಊಟ ಮಾಡಿದ ಮೇಲೆ ಯಾವುದಾದರೂ ಮಗು ಅಸ್ವಸ್ಥವಾಗಿದೆಯೆ?	1	ಹೌದು	
		2	ಇಲ್ಲ	
		3	NR	
48	ಹೌದು ಎಂದಾದಲ್ಲಿ, ಸಾಮಾನ್ಯವಾಗಿ ಎಷ್ಟು ಬಾರಿ ಆಗಿದೆ	1	ಬಹುತೇಕ ಪ್ರತಿದಿನ	
		2	ಹೆಚ್ಚು ಬಾರಿ	
		3	ಕೆಲವು ಬಾರಿ	
		4	ಎಲ್ಲೋ ಒಂದೆರಡು ಬಾರಿ	
		5	NR	
49	ಊಟ ಮಾಡಿದ ಮೇಲೆ ಕಂಡು ಬರುವ ಅನಾರೋಗ್ಯ ಎಂತಹದು ವಿವರಿಸಿ Assesment			
50	ಈ ಹಳ್ಳಿಯಲ್ಲಿ ಮಧ್ಯಾಹ್ನದ ಊಟ ಆರಂಭಿಸಲು ಏನಾದರೂ ವಿರೋಧವಿತ್ತೆ?	1	ಹೌದು	
		2	ಇಲ್ಲ	
		3	NR	
51	ಹೌದು ಎಂದರೆ, ಯಾರಿಂದ, ವಿವರಿಸಿ			
52	ಈ ಶಾಲೆಯಲ್ಲಿ ಮಧ್ಯಾಹ್ನದ ಊಟ ಮುಂದುವರಿಸಬೇಕೇನು?	1	ಹೌದು	
		2	ಇಲ್ಲ	
		3	NR	

53	ಬೇಡ ಎಂದಾದರೆ, ಯಾಕೆ, ವಿವರಿಸಿ. ಬೇಕು ಎಂದಾದಕೆ ಯಾಕೆ ವಿವರಿಸಿ.			
54	ನಿಮ್ಮ ಅಭಿಪ್ರಾಯದಂತೆ, ಮಧ್ಯಾಹ್ನದ ಊಟ ನಿಮ್ಮ ಶಾಲೆಯಲ್ಲಿ ಎಂತಹ ಧನಾತ್ಮಕ ಬದಲಾವಣೆಗಳನ್ನು ತಂದಿದೆ?			
55	ಇದು ತಂದಿರುವ ಋಣಾತ್ಮಕ ಬದಲಾವಣೆಗಳು ಯಾವುವು ಇದ್ದಲ್ಲಿ			
56	ಮಧ್ಯಾಹ್ನದ ಊಟ ಕುರಿತು ನೀವು ನೀಡಬಹುದಾದ ಸಲಹೆಗಳು ಇದ್ದಲ್ಲಿ ಹೇಳಿ.			

VIII. ಶಿಕ್ಷಕರ ವಿವರ : **Teacher's Details**

57	ಲಿಂಗ :	58	ವಯಸ್ಸು	
59	ಜಾತಿ /ಧರ್ಮ	1	ಎಸ್.ಸಿ.	
		2	ಎಸ್.ಟಿ	
		3	ಒ.ಬಿ.ಸಿ	
		4	ಸಾಮಾನ್ಯ ವರ್ಗ	
		5	ಮುಸುಲ್ಮಾನರು	
		6	ಇತರೆ (ಸ್ಪಷ್ಟ ಮಾಡಿ)	
		7	ಉತ್ತರವಿಲ್ಲ NR	

IX. 2002 ರ ಶಾಲಾ ದಾಖಲಾತಿ : Enrollment as in 2002– 2001-2002

	ಎಸ್.ಸಿ/ಎಸ್.ಟಿ			ಒ.ಬಿ.ಸಿ			ಸಾಮಾನ್ಯ			ಒಟ್ಟು		
	ಗಂಡು	ಹೆಣ್ಣು	ಒಟ್ಟು	ಗಂಡು	ಹೆಣ್ಣು	ಒಟ್ಟು	ಗಂಡು	ಹೆಣ್ಣು	ಒಟ್ಟು	ಗಂಡು	ಹೆಣ್ಣು	ಒಟ್ಟು
1 ನೇ ತರಗತಿಗೆ ದಾಖಲಾತಿ												
ಒಟ್ಟು												

Enrolment 2002-2003

X. ~~ಹಾಜರಾತಿ ಪಟ್ಟಿ : Attendance Charts~~

~~ಈ ಸರ್ವೇಕ್ಷಣೆಗೆ 30 ದಿನಗಳಿಗೆ ಮುಂಚಿನಿಂದ ಸರಾಸರಿ ಮಕ್ಕಳ ಹಾಜರಾತಿ (2003)~~

	ಎಸ್.ಸಿ/ಎಸ್.ಟಿ			ಒ.ಬಿ.ಸಿ			ಸಾಮಾನ್ಯ			ಒಟ್ಟು		
	ಗಂಡು	ಹೆಣ್ಣು	ಒಟ್ಟು	ಗಂಡು	ಹೆಣ್ಣು	ಒಟ್ಟು	ಗಂಡು	ಹೆಣ್ಣು	ಒಟ್ಟು	ಗಂಡು	ಹೆಣ್ಣು	ಒಟ್ಟು
1 ನೇ ತರಗತಿಗೆ ದಾಖಲಾತಿ												
ಒಟ್ಟು												

XI., ಸರ್ವೇಕ್ಷಣೆ ಮಾಡಿದವರ ಟಿಪ್ಪಣಿ Investigator's Comments

ದಯಮಾಡಿ ನಿಮ್ಮ ಅಭಿಪ್ರಾಯಗಳನ್ನು ದಾಖಲಿಸಿ.

CONSTITUTION OF BOARD OF VISITORS FOR THE HEALTH FACILITIES OF BANGALORE MAHANAGARA PALIKE

****

There are 30 Maternity homes being run by Bangalore Mahanagara Palike. These hospitals have 24 or 30 beds each and cater to the Urban Poor mainly. The services provided range from general medical care, Ante-natal Services, delivery services, MTP's, sterilisations, Family Welfare Services, Immunization, Basic Laboratotory investigations etc.,

There are 55 Health Centres run by the India Population Projectt-VIII. These along with 37 UFWC's provide day care health facilities and Primary Health Care.

OBJECTIVES OF CONSTITUTING BOARD OF VISITORS.

* To ensure proper over sight and good governance of health facilities through the participation of both public and private sector representatives.

* To seek and utilize feed back on services with a view to providing quality care and improving accountability.

* To institutionalize Best Practices in health care.

* To provide a forum for the staff of the health facilities to present their plans performances and problems.

* To ensure stronger community involvement and ownership in the facilities and the services.

* To play a proactive role in the mobilization and use of resources in the health facilities.

Constitution of Board of Visitors.

A Board of visitors will be constituted for 4-5 hospitals coming under a particular superintendents zone.

The following will be the constitution of the Board of Visitors.

* The Councillor of the concerned wards will be members. One amongst them will be nominated to act as chairperson by the other members.

* The Superintendent of the Zone will be the convenor.

* A representative of a locally functioning NGO.

* A respected person in the locality who may be a retired person with a desire to serve the community.

* Principal of a Local Government / Corporation School.

* Rotary / Lions / Local industrialists/ Medical Practitioners.

At least 2 of the members must be women.

Specific Responsibilities/ Activities of the Board.

1) Quarterly review meetings.
2) Review of activities of the Health Facilities in the Jurisdiction.
3) Review plans budgets programmes and performances of the health facilities.
4) Review and approve income from the user charges or other sources and expenditure out of such funds.
5) Resource mobilization.
6) Review and re dressal of un resolved public complaints received.
7) Proposal of measures for better governance
8) Any other subject of relevance.

This committee has no jurisdiction over administrative matters like appointment of staff, transfers and confidential reports etc. However it can recommend suggestions to improve the management practices and services.

Selection of members of the Board.

The Superintendent in whose zone the committee is constituted will prepare the names as per the guidelines given above, to be approved by a committee consisting of

Joint Commissioner (Health & Education)	-	Chairperson
Zonal Deputy Commissioner	-	Member
Project Co-Ordinator, IPP-VIII	-	Member
Chief Health Officer	-	Member

Quorum for the meeting:- At least 50% of the members should be present for the meeting. If the chairman of the committee is not present, the members present may nominate one among the members, other than the convenor to chair the session. Any member absent continuously for 3 meetings his or her name may be deleted from the committee.

Minutes Book:- Convenor will convene the meeting every quarter and will maintain the minutes of all meetings.

Bank Account:- Action will be taken by the Lady Medical Officer to open a joint account in the nearest nationalized bank for remitting money collected as user fees or public donations. The joint account holders will be the Lady Medical Officer and one representative from an NGO nominated by the Board of Visitors.

Board Guidelines for using the funds:- The amount collected by each facility may be utilized for the following purposes.

1. Emergency purchase of Drugs & Equipments not available in the stores.
2. Minor repairs to equipments supplied
3. Purchase of plugs, sockets, bulbs etc., for the Health Centre.
4. Xeroxing, Postage, Stenciling & Stationary etc.
5. Minor Civil repairs including plumbing, electricity etc.

Period of the Committee:- The Board of visitor so constituted by the orders of the commissioner based on the recommendation of the selection committee will be in force for a minimum period of two year initially which may be extended for one more year. There after the committee will be reconstituted.

TERMS & CONDITIONS OF HELP DESK

1. The NGO will provide lady volunteers round the clock in 8 hours shifts to serve at the "Help Desk".

2. The Volunteer will act as a liaison between the public and the hospital to provide the services in case of any difficulty.

3. The volunteer will assist those who approach the desk to obtain required services, information and guidelines.

4. The volunteer will assist the public in obtaining information pertaining to services in the hospital.

5. The IPP-VIII will provide a table and chair for the volunteer, at the entrance.

6. The IPP-VIII will provide a display board in different languages in the hospital to inform the public of this service.

7. The Hospital staff shall respond to the volunteer and immediately attend to the request.

8. The field staff of the UFWC attached to the Maternity Home shall publicize the information regarding the Help Desk.

9. An orientation programme of the hospital staff and volunteers to define their roles will be organised by the IPP-VIII.

10. Any problem encountered by the volunteer will have to be solved by the Lady Medical Officer of the Maternity Home, the superintendent and other officers.

11. The volunteer will be allowed the use of the telephone for official purposes.

12. Assistance given by the volunteer will be documented.

CITIZENS CHARTER – RIGHTS OF THE CITIZEN

The Citizen has a Right to

* The following Health Services

  - General Medical Care
  - Ante Natal Care
  - M.T.P.
  - Sterilization
  - Laboratory
  - Delivery
  - Immunization
  - Family Welfare
  - T.B. Control

* The services of the Medical Officer from 9.00 AM to 4.00 PM.
* The services of the doctor for emergencies round the clock.
* In-patient services round the clock.
* Timely Appropriate Referral Care.
* Ambulance services in Emergency Situations
* User charges as prescribed, all other services being FREE.

  - Laboratory Facility - Rs. 10=00
  - In-Patient charges - Nil
  - M.T.P. - Rs. 100=00
  - Minor Surgical Procedure - Rs. 100=00

* Clean and Neat environment with good house keeping.
* Hospital will be cleaned at 7.00 AM, 2 P.M. & 9.00 P.M.
* Toilet will be cleaned at 7.00 AM, 2 P.M. & 9.00 P.M.
* Clean Linen will be provided daily.
* Polite courteous behaviour from all staff.
* High Quality Health Care.
* Be attended to within ½ an hour. In emergencies attention will be immediate
* Milk (250ml) twice a daily and 1 loaf of bread.
* Seek redressal of a complaint.

The Patient has a responsibility to

* Keep the environment clean.
* Follow medical advice of the doctor.
* Maintain harmony with staff and other patients.
* Safeguard hospital property.
* Insist on receipt for chargeable services
* Discourage Bribery.
* Participate in the hospital improvements

ATTENDANTS RESPONSIBILITIES

* Keep the environment clean.
* Follow medical advice of the doctor.
* Maintain harmony with staff and other patients.
* Safeguard hospital property.
* Insist on receipt for chargeable services
* Discourage Bribery.
* Adhere to the visiting hours.

Main Identity

From: "JANAAGRAHA" <janaagraha@vsnl.net>
To: <SOCHARA@VSNL.COM>
Sent: Monday, August 18, 2003 6:13 PM
Attach: Ward Planning Campaign intro 8.18.doc; urban poor w'shop note final.doc
Subject: Urban Poor in B'lore Workhop

Mr. Chandar and Dr. Narayan,

Janaagraha is undertaking its second phase with the Ward Planning Campaign (see attached letter). This programme will facilitate the development of a three-year perspective plan in each ward.

The urban poor are an important, but often marginalized group of residents of their city and their local area. We want to include them in the full process of ward planning, but also take time to address their unique concerns. Attached is a one page document on the Preliminary workshop for the urban poor.

We are currently reaching out to experts in the ten issues that are relevant to slumdwellers. Health is one of the most critical issues, and we hope to have your input and participation in the workshop and subsequent activities. You both have tremendous experience both with the complex public health issues, as well as the poor communities in Bangalore.

Please take a look at these documents and let us know if you are interested in participating in this part of the campaign. I look forward to hearing from you.

Elizabeth Clay

JANAAGRAHA
#198,Nandidurg Road
Bangalore-560046
Ph. 3542381,3542382,3542977
Fax: 080-3542966

Dear Elizabeth,

1. Thank you for your letter regarding the Ward Planning Campaign. It is an important initiative. Chandar & Rajendran John CHC are involved with issues of the urban poor. Health & Xavier are on a Health + related fellowship & placement with CHC currently & are also focusing on urban poverty. Getting urban poor communities to voice their concerns, to practise & strategise is important. Communities where our team works have consistently raised the issue of alcohol abuse related to the early availability & lack of regulation of alcohol sales & in fact its active promotion by Govt. One or more of the 4 team members will participate in the programmes mentioned by you.

2. You may be aware of the People's Health Movement. The Jan Swasthya Abhiyan at national level. The state level group is called the Jan Arogya Andolana. A peoples charter for health has been developed and is available in Kannada & English. Currently we have two ongoing campaigns

8/19/03

the Right to Healthcare Campaign + Human Watch. There is also an ongoing campaign against female foeticide. In Karnataka we have had a series of 9 workshops on Primary Health care in different districts. The Karnataka Health Task Force also focussed on strengthening primary health care and public health. Dr Anjaya Andrade is going to conduct two training workshops on herbal remedies in Belgaum and Tumkur in Sept/Oct.

With best wishes + assuring you of our support

Yours
19/5/03

JANAAGRAHA

Janaagraha | Teams up for a Better Bangalore

Ward Planning Campaign: Preliminary Workshop for the Urban Poor

The Ward Planning Campaign at Janaagraha will consist of 5 structured workshops for all citizens of 10 target wards to identify their local issues and create a 3-year perspective plan of their ward. A wide range of citizens will plan to improve their roads, upgrade parks and address solid waste management and quality of life issues that affect their everyday lives. During the 4-month process, they will discuss and cost possible solutions, and prioritize their needs.

A large segment of each ward's population live in slums. The everyday needs of these communities are related to more basic infrastructure such as water supply, community toilets, sewerage, and health. On August 30th, Janaagraha will hold a preliminary planning workshop for the urban poor citizens of the ten wards. This event is not a substitute for the main workshops, but an important supplement to the larger process, so that the urban poor are better equipped to participate in these larger processes.

This session is critical for several reasons. First, though the concerns in the slums are "basic infrastructure", many are quite complex in the implementation and require more than one agency for proper execution. This session will offer an opportunity for multiple agencies to address the compound nature of the problem and their role in any solution. Second, because of the complexity of the issues, and their near exclusivity to slums, it is important that the residents have enough time to discuss their needs before entering the larger workshops where there will be less time for each problem. If only representative slum-dwellers are present for the five workshops, it should not mean that critical concerns were not considered. Third, the focused workshop will give them an opportunity to use the map tools for their own (sub-neighborhood level) areas and give them familiarity with the planning methodologies used in the mainstream workshop sessions.

On September 6th, the residents of 65 slums in the ten wards will convene as a slum community, and split up into the 10 issue sectors. Each sector group will discuss the problems within that issue (example: Issue- Health, Problems- "No Primary Care Facility", "Children are not Vaccinated"). After identifying the problems, the citizens will explore the potential solutions with agency heads and issue experts and each solution's feasibility. The outputs from this preliminary session will be valuable to the full participatory planning process:

- Specific problems will be identified for each slum in most issue areas for the 1st workshop.
- The discussion on solution feasibility will be valuable in the 2nd workshop discussion on solutions for all identified problems.
- After the Urban Poor Workshop, the relevant agencies can estimate costing for the most common and complex concerns across slum areas, which will be used at the 3rd workshop on costing.

All of these outputs from this session will ensure that the issues from the slum areas are not marginalized at the mainstream workshops.

August 18th, 2003

Dear Friends,

Sub.: Citizen participation in local-level planning

Janaagraha has brought a different approach to the issue of public governance, specifically urban local government.

- Janaagraha's first Ward Works campaign has given community groups and residents a platform to be involved with the process of prioritizing for the Ward Works budget. Thousands of citizens in many wards have worked together to decide what improvements they want to see in their own areas, and worked constructively with you, their Corporators and BMP Engineers to see those changes made.
- Janaagraha's second campaign called PROOF was launched in partnership with 3 other civil society institutions: Public Affairs Centre, VOICES and CBPS. This campaign has completed one year, and has been heralded as one of the international best practices in disclosure by governments. The elected leadership and administration of the BMP have actively participated in this campaign, and in fact led many of the activities in the campaign.
- The third campaign of Janaagraha was also in conjunction with the government, this time both with the BMP and the DMA. This has been to revitalise the Urban Poverty Programme called Swarna Jayanti Shehari Rozgar Yojana (SJSRY) in Bangalore. The DMA has taken leadership in this activity, and a 6-month pilot project is currently under way in Bangalore, with the involvement of the government, the banking system, the NGO sector and the poor. Already, the results of the project have reached 50% of the record of the past 4 ½ years.

After 18 months, we have completed the first phase of Janaagraha. We are now taking the next step by launching a campaign for the generation of a 3-year Ward Plan, with the involvement of the BMP, the citizens, , and other concerned agencies. In this process we will consider many issues that affect us as residents including parks, garbage and sanitation, water and sewerage, roads, drains and quality of life concerns.

In keeping with the approach of Janaagraha, a comprehensive and professional approach has been designed, taking best practices from other states in the country and all over the world, into account. A few such examples in our country are the Bhagidari plan launched in Delhi by Smt Sheila Dixit, and the decentralised planning process that has been implemented in Kerala.

This programme launched on Independence Day, and will be spread over the next 4 months, with specific grassroot-level activities in each of the participating wards. The ten wards (out of 100) have been identified for the extraordinary atmosphere for citizen participation, and have all been taking part in the Monthly Review Meeting process for a few months.

Hundreds of individuals have worked together on different aspects of the process so that citizens have a useful framework within which to engage. The following are some of the details:

JANAAGRAHA Participatory Planning Process Elements	Participants	Purpose	Details
Ward Survey	700+ students from seven colleges.	To collect up-to-date, ground-level information about all properties in the target wards. BDA will use the citizen planning outputs as input for the CDP revision	Groups of students were trained to capture important building information; the process was meticulous and carefully detailed
Expert Panel	Over 50 professionals and bureaucrats with extensive subject matter experience	To give Bangalore-specific, cutting-edge, expert guidance on costing and current policy in each of the issue and solution areas.	The fields of the expert panels include: Roads, Water Supply, Environmental Issues, Traffic and Transportation and others
Usage of Maps	Use of latest satellite mapping technology available to generate maps of high accuracy and detail as planning tools	Maps are easy for all citizens to understand and allow citizens to discuss their neighborhood in a comprehensive manner as a group	We will use maps to sensitize citizens in our communications activities, then they will identify issues on the maps as individuals and as a group; each workshop will also include several "thematic" maps, such as water supply and sewerage, public / semipublic places, etc. of each ward
Community Training	200 Active Community members, approx. 20 from each of the target wards	Both at the individual and group levels, citizens can be more successful in their endeavors if they improve their communication, negotiation and planning skills.	Competency Development Strategies (CDS) is currently running two training sessions to the communities in Team Building and Meeting Management.
Janaagraha Community Development Fund	The first participating Federation is Abyudaya in Ward 55.	To aid the functioning of community Federations at the ward level, for a minimum period until they are self-sustaining.	The funding requirements are being met through private funders who support the idea of community engagement with local governance issues.

Citizens will participate in a set of 5 workshops in each ward, held on Sundays. Each workshop will build on the activities of the previous workshop. The topics covered during the workshops are: ISSUE IDENTIFICATION, EXPLORING SOLUTIONS, COSTING AND REVENUE ANALYSIS, BUILDING THE PLAN, and finally THE WAY FORWARD.

Another important event will be held during the last week of August. We will have a special workshop for the poor in the slums in the ten target wards to discuss the important needs of the urban poor, before they participate in the main 5 workshop sessions. Your participation at this workshop is very important., the event has tentatively been scheduled for the 30th August; however, we will confirm the date, time and location.

This campaign will be an innovative step to bringing better quality public governance through citizen participation.

Your support has been valuable to us in the last 18 months and we hope to have your continued encouragement and collaboration with this campaign. You can be involved in many ways depending on your interests and time, but we hope you can join us in some capacity. Please be in touch with ay questions, comments or on how you can engage with this second phase of Janaagraha directly.

Sincerely

Swati Ramanathan
Campaign Coordinator

draft

Main Identity

From: "Community Health Cell" <sochara@vsnl.com>
To: "JANAAGRAHA" <janaagraha@vsnl.net>
Sent: Tuesday, August 19, 2003 4:36 PM
Subject: Re: Urban Poor in B'lore Workhop

Dear Elizabeth,

1. Thank you for your letter regarding the Ward Planning Campaign. It is an important initiative. Chander and Rajendran from CHC are involved with health and related issues of the urban poor. Re Dr. Mathew and Xavier are on a fellowship and placement with CHC currently and are also focussing on urban poverty. Getting urban poor communities to voice their concerns, to prioritise and strategise is important. Communities where our team works have consistently raised the issue of alcohol abuse related to the easy availability and lack of regulation of alcohol sales and in fact its active promotion by government. One or more of the 4 team members will participate in the programmes mentioned by you.

2. You may be aware of the Peoples Health Movement, the Jan Swasthya Abhiyan at national level. The state level group is caled the Jan Arogya Andolana. A Peoples Charter for Health has been developed and is available in Kannada and English. Currently we have two ongoing campaigns the Right to Health Care Campaign and Hunger Watch. There is also an ongoing campaign against female foeticide. In Karnataka we have had a series of 9 workshops on Primary Health Care in different districts. The Karnataka Health Task Force also focussed on strengthening primary health care and public health. Jana Arogya Andholana is going to conduct two training workshops on herbal remedies in Belgaum and Tumkur in September ~~/ October~~.

with special recommendations for urban areas

With best wishes and assuring you of our support.

With regards,

Yours sincerely,

O/L

Best 20/8/03

Dr.Thelma Narayan

SJC / SDR / Mathew + Xavier to see

8/19/03

Main Identity

From: "JANAAGRAHA" <janaagraha@vsnl.net>
To: "Dr.H.Sudarshan" <hsudarshan@vsnl.net>
Cc: <sochara@vsnl.com>
Sent: Wednesday, October 08, 2003 1:32 PM
Subject: Meeting - Performance Indicators for health

Dear Dr. Sudarshan,
The meeting on Performance Indicators for health has been scheduled for Wednesday the 15th of October at 9:30 AM at the Janaagraha office.
Dr. Paresh Kumar and Mr. Chander from Community Health Cell will also be attending the meeting.
Regards,
Preetha

JANAAGRAHA
#198,Nandidurg Road
Bangalore-560046
Ph. 3542381,3542382,3542977
Fax: 080-3542966

9/10

Chander & Paresh have confirmed to 15th

Thanks
9/10

Main Identity

From: "JANAAGRAHA" <janaagraha@vsnl.net>
To: "Dr.H.Sudarshan" <hsudarshan@vsnl.net>; <sochara@vsnl.com>
Sent: Tuesday, October 07, 2003 12:52 PM
Subject: Meeting on Saturday

Dear Dr. Sudarshan and Dr. Thelma,

This is just to check with you on the Saturday (11th October) meeting scheduled at Janaagraha to discuss Performance Indocators for health. Please do let me if I can confirm this meeting. I would appreciate it if you could also confirm the time that you would prefer to hold this meeting.
Regards
Preetha

JANAAGRAHA
#198,Nandidurg Road
Bangalore-560046
Ph. 3542381,3542382,3542977
Fax: 080-3542966

6393508 — SAT Please confirm on Phone at his residence after 7pm

Sjc You may wish to attend
Please indicate

Thanks
PK
8/10/03

PK
8/10 — Meeting has been Postponed to 15/10/03
— Telephone Message received by NH on 8/10/03
— Message Conveyed to Sjc through AP
PK
8/10.

9/11/03

Urban Poor Workshop Outcomes
September 10th

Health

At the Janaagraha Urban Poor Workshop, residents of 31 slums participated in sector-wise discussions about ten important infrastructure and service issues.
The discussion on Health, like the other 9 topics, was led by both a facilitator and an expert in the field and each participant discussed the major concerns in their area. They compiled a list of the following critical health problems and service gaps that affect slum dwellers:

Prevention

1. Lack of proper sanitation facilities
2. Lack of proper immunization to children (particularly Hepatitis, which is too costly).
3. Residents want awareness programs about HIV/AIDS and other diseases
4. No medical care available for many pregnant women and infants

Health Services and Facilities

1. Local facilities cannot handle emergencies, they refer residents to expensive facilities
2. Lack of Gov't/Corporation hospital facility that is nearby, often residents must travel over 7 or 8 km to find an affordable facility
3. Without paying money cannot receive treatment at government hospitals, despite the fact that care is officially free.
4. Doctor should be 24 hours, often arrive at facility and no doctor or nurse is available

Common Diseases that are not being adequately addressed: Dengue Fever, Tuberculosis, Skin Diseases, Diarrhea, Wheezing and Typhoid

Hospitals are needed in the following Wards: 54, 55, 68, 96 and 100.

Main Identity

From: "JANAAGRAHA" <janaagraha@vsnl.net>
To: <SOCHARA@VSNL.COM>
Sent: Wednesday, September 10, 2003 4:25 PM
Attach: upw health outcomes.doc
Subject: urban poor workshop

Mr. Chander,

Thanks for your participation- as you requested I am sending you the outputs from the workshop session on health. be in touch with any questions or response.

Best Regards,
Elizabeth
JANAAGRAHA
#198,Nandidurg Road
Bangalore-560046
Ph. 3542381,3542382,3542977
Fax: 080-3542966

Main Identity

From: "JANAAGRAHA" <janaagraha@vsnl.net>
To: <SOCHARA@VSNL.COM>
Sent: Friday, August 29, 2003 5:02 PM
Attach: u.p. new p&s grid.xls
Subject: follow up information on September 6th event

Dear Dr. Narayan and Mr. Chander,

Thank you very much for agreeing to participate in the Urban Poor Workshop on September 6th. We are looking forward to a productive and successful event that will support residents of approximately 40 slums in ten focus wards to make positive changes for their communities. We have four specific objectives for this event:

- Orient the urban poor to the methodologies to be used in the larger Ward Vision workshops including exercises, use of maps and methodical identification of problems and solutions. This will make their participation a fruitful, enriching experience for both the poor and the middle class.
- Create a forum that transcends greivance redressal and instead analyzes specific answers and solutions from each agency.
- Understand the complex nature of both the problems and solutions (as some will be different from middle-class areas) and take steps towards addressing them.
- Encourage the slumdwellers to participate in the five workshops held in their ward between September and December.

The tentative agenda is as follows:

2-2:30 Registration and tea

2:30-2:45 Introduction to Workshop (by Conductor)

2:45-3:30 Conductor presents list of sectors; Communities divide their group into sectors so that each sector being discussed has a participant from every slum. Everyone moves into smaller rooms to discuss thenature of the problems within one issue area

3:30-4 In 10 sector rooms: Each room discussion focuses on a single sector only. Discussion of Problems and Solutionsaffecting each slum within that particular sector.(using pre-determined grid, guided by facilitator, documented by volunteer)

4:00- 5:00 Interactive session between communities and agency head and/or sector expert to discuss feasibility of solutions.

5:00 – 5.30: tea and snacks

As the sector expert you will play a critical role in the workshop. The role is not that of an advocate for the residents. Identification of problems should come directly from the urban poor themselves as far as possible. Following are the expectations of sector experts in each of the smaller groups:

TH

Do you need these attachments - (yes) good punctuality P.

To SJC+SDR

4/9

4/9.

9/1/03

1. Facilitate open group discussion in the sector rooms both in identifying problems and the one-hour session with agency head.

2. Give valuable inputs where gaps are left in the discussion on potential causes of problems, gaps in the system (of a larger nature that individual slums) and innovative solutions.

3. In the absence of senior representative from the respective agency / adminstration, serve as principal resource on possible solutions. Solutions that the group determines based on this discussion will be sent to that agency head for comments before the main workshops.

Resources at the Workshop (all written material in Kannada):

- ✓ Large pre-defined problem-solution grid posters for each sector. These posters will include the problems and solutions that we have identified and blank spaces for specific concerns that we have not yet considered. This may be a useful tool for the first part of the session.

- ✓ Large slum-wise solution grid which will aid in plugging in potential solutions for each represented slum.

- ✓ Two-sided sheets with maps of areas on one size and list of all sector areas with icons on other side.

- ✓ We will also have volunteers who will help with registration, documentation and other responsibilities throughout the workshop.

Please be in touch with Elizabeth at Janaagraha with any questions or clarifications about the event. We look forward not only to your participation at the workshop, but to your valuable contributions before and after September 6th.

Attached please find the defined problems and solutions for the sector you will facilitate. This is a first cut, so please make additions and corrections to Health if needed so we may refine it in the next few days.

Best regards,

Swati Ramanathan

Campaign Coordinator

JANAAGRAHA

JANAAGRAHA

9/1/03

Main identity

From: "Dr.H.Sudarshan" <hsudarshan@vsnl.net>
To: "JANAAGRAHA" <janaagraha@vsnl.net>; <sochara@vsnl.com>
Sent: Wednesday, October 08, 2003 4:46 AM
Subject: Re: Meeting on Saturday

Dear Preetha

For me 15th or 16th October is conveneint for me.9.30AM would be convenient.

With regards

Sudarshan

PK

8/10

Main Identity

From: "JANAAGRAHA" <janaagraha@vsnl.net>
To: "Dr.H.Sudarshan" <hsudarshan@vsnl.net>; <sochara@vsnl.com>
Sent: Tuesday, September 30, 2003 7:42 PM
Attach: Referral Hospitals.xls; PI for Health Note Sep 30.doc
Subject: PROOF - Performance Indicators

Dear Dr. Sudarshan, Dr. Thelma and Mr. Chander,
Please find attached a write up based on our interaction at CHC last Thursday. Please review the document and let me know if I have captured all the points that you had raised.
I am also attaching information that we had collected from the Referral Hospitals of the BMP for your reference to give you an idea of the kind of information we have collected.
Looking forward to your response.
Regards,
Preetha
JANAAGRAHA
#198,Nandidurg Road
Bangalore-560046
Ph. 3542381,3542382,3542977
Fax: 080-3542966

Dear Preetha,
Thanks for the note - will get back with comments shortly.

10/1/03

PERFORMANCE INDICATORS FOR HEALTH

Background:

Over the past nine months (Year 1 of the PROOF campaign) the PROOF team has been working on developing performance indicators for the health department of the Bangalore Mahangara Palike.

Performance Indicators are means by which the efficiency and effectiveness of activities can be assessed as well as a means of providing objective information to the involved stakeholders.

A four-stage process has been identified to develop these indicators, these are:

1. Identifying specific performance indicators for health through an interactive process involving the stakeholders.
2. Data collection from Referral hospitals, Maternity homes, Family Welfare centres Health Centres and Dispensaries.
3. Data analysis based on the collected information
4. Management Discussion using performance indicators as the basis for objective identification of successes and problem areas as well as specific solutions

The PROOF team has thus far developed 52 indicators for the Health department as well as completed data collection from all the BMP institutions based on these indicators. Data Entry has also been completed for 24 Maternity Homes as well as 6 Referral hospitals.

In the second year of the campaign focus with respect to the Health indicators would be to bring into the campaign a partner with expertise in the area of health care in order that the performance measurement system can be further developed and applied towards improving the quality of service delivery in these institutions.

Meeting at Community Health Cell:

Following an initial meeting with Dr. Sudarshan at his office to discuss opportunities for partnership a second review meeting was held at the Community Health Cell with Dr. Sudarshan, Dr. Thelma Narayan and Mr. Chander to review the work of the PROOF campaign (represented by Preetha Radhakrishnan) as well as define a broad agenda for partnership between PROOF, CHC and Karuna Trust.

The following points were raised at the meeting as points to be considered while defining the scope of the performance indicator activity:

- The performance indicators developed by the PROOF campaign are comprehensive. However these indicators will help assess the strengths and weaknesses at the institution level.
- In order to make the study more effective in terms of policy recommendations an analysis of the entire system (BMP Health Department) needs to also be done.
- This study would cover aspects related to Budget allocations for health, Duties and functions of the BMP with respect to health care, Current Policies and procedures followed by the Health Department. Such a comprehensive study would supplement the data gathered with the help of the performance indicators and provide information while making policy recommendations.
- As partners in the PROOF campaign Karuna trust and CHC would facilitate this study and provide all required inputs.

- While studying the performance of the Health department, the current scope of the performance indicator framework should be expanded to emphasis the Preventive and Promotive aspects of health care.
- Given the technical nature of health care an intervention programme similar to the one currently being implemented by Akshara Foundation in the area of Education as a partner in the PROOF campaign may not be possible. Over the course of the next two weeks a programme objective will be defined clearly.

Next Steps:

- Meeting to be held with Dr. Sudarshan, Dr. Thelma Narayan, Mr. Chander and Mr. Ramesh Ramanathan to discuss the scope and objectives of the partnership. This meeting is tentatively scheduled for the 11th of October.
- A prior meeting between Mr. Chander and Preetha share the information collected by PROOF as well as CHC with respect to the BMP health department.

S.NO	FORM NUMBER		RR:1	RR:2	RR:3	RR:4	RR:5	RR:6
I.a	NAME		Sreerampura Referral Hospital	Hosahalli Referral Hospital	Banashankari Referral Hospital	Ulsoor Referral Hospital	J.J. Nagar Referral Hospital	H. Siddaiah Road Referral Hospital
I.b	FUNCTIONALITY		Referral	Referral	Referral	Referral	Referral	Referral
I.c	ADDRESS		Sreerampura Bangalore- 21	5th main road, MC Layout Vijayanagar Bangalore-40	BSK II Stage, 27th Cross, Bangalore-70	Cambridge Road, near Ulsoor Police Station, Bangalore	9th Main Road, Padaragarapura, Bangalore -26	JC Road Bangalore-2
I.c	PHONE		3128447	3350810	6716596	5551324	6748487	2235037
I.d	WARD		24	36	na	na	44	na
I.e	YEAR OF INCEPTION		1962	1975	na	na	1999	1975
II	INPUT							
	INFRASTRUCTURE							
1	General Ward		2	2	2	3	2	2
2	Labor Ward		2	1	2	2	1	1
3	Operation Theatre		1	1	1	1	1	2
4	Minor Operation Theatre			1	1	1	1	1
5	Laboratories		1	1	1	1	1	1
6	Toilets		9	10	9	8	8	6
7	Condition of Toilets		Satisfactory	Not satisfactory	Satisfactory	Satisfactory	Satisfactory	Not satisfactory
8	Inpatient Bathrooms	Availability	adequate	na	adequate	adequate	adequate	na
		Number	6	2	4	3	3	3
9	Outpatient Bathrooms	Availability	not ad	na	adequate	not adequate	adequate	na
		Number	0	0	0	2	na	1
10	Availability of Linen Service		yes	yes	yes	yes	yes	na
11	Daily linen change		yes	yes	yes	no	yes	no
12	Availability of Drinking Water		yes	yes	yes	no	no	yes
13	Quarters for Doctors and Ambulance Drivers	Availability	available	available	available	available	available	available
		Number	1	3	na	3	2	na
14	Waiting Areas for Inpatient	Availability	not ad	not ad	adequate	adequate	not ad	not ad
		Number	0	0	na	1	na	na
15	Waiting Areas for Outpatient	Availability	adequate	not ad	adequate	adequate	not ad	adequate
		Number	1	1	na	1	na	na
16	Waiting Areas for Attendant	Availability	adequate	not ad	adequate	not adequate	not ad	not ad
		Number	1	0	na	0.33	1	na

17	Generator Sets	Availability	adequate	adequate	adequate	not adequate	adequate	adequate
		Number	1	1	na	1	1	na
18	Store rooms	Availability	adequate	not ad	adequate	adequate	not ad	not ad
		Number	2	1	na	1	1	na
19	Ambulance Services		available	available	available	available	available	available
20	Telephone Services		available	available	available	available	available	available
21	Privacy of examination area		available	available	available	available	available	available
22	Periodicity of fumigation	Operation Theatre	available	available	available	available	available	available
		Minor Operation Theatre	not available	available	available	not available	available	available
		Labour Ward	available	available	available	available	available	available
	EQUIPMENT							
23	Outpatient Ward	Examinatio n Room	available	available	available	available	available	available
		Table for Doctor	available	available	available	available	available	available
		Stool / Chair for Outpatient	available	available	available	available	available	available
		Footstep	available	available	available	available	available	available
		Emergency Tray	available	available	available	available	available	available
		Refrigerator	available	available	available	available	available	available
24	Labour Ward	Labor cot	available	available	available	available	available	available
		Footsteps	available	available	available	available	available	available
		Waste Disposal	available	available	available	available	available	available
		Emergency Tray	available	available	available	available	available	available
		Oxygen	available	available	available	available	available	available
		Drip Stands	available	available	available	available	available	available
		2000 Watt Lamp / Radiant Warmer / Phototherap	available	available	available	available	available	available

25	Operation Theatre	Operation Theatre Table	available	available	available	available	available	available
		Footsteps	available	available	available	available	available	available
		Waste Disposal Mechanism s	available	available	available	available	available	available
		Emergency Tray	available	available	available	available	available	available
		Oxygen Cylinder	available	available	available	available	available	available
		Drip Stands	available	available	available	available	available	available
		2000 Watt Lamp / Radiant Warmer / Phototherap y Warmer	available	available	available	not available	available	na
		Anesthetic Equipments	available	available	available	available	available	available
26	Laboratory	Antigens and Reagents	available	available	available	available	available	available
		Waste disposal Mechanism s	available	available	available	available	available	available
	DRUGS							
27	Availability of minimum essential drugs		yes	yes	yes	yes	yes	yes
28	Availability of minimum emergency drugs		no	no	yes	yes	yes	no
	FURNITURE							
29	Minimum Required furniture		yes	yes	yes	yes	yes	na
30	Waiting Area	Benches	available	available	available	available	available	available
		TV / VCR	available	available	available	available	available	available
31	Labor Ward	Cots	available	available	available	available	available	available
		Mattresses / Pillows	available	not ad	available	available	available	available
32	Doctors Room	Tables	available	available	available	available	available	available
		Chairs	available	available	available	available	available	available
	STATIONARY							
33	Stationary for correspondance		yes	yes	yes	yes	yes	yes
34	Monthly for reporting formats		no	yes	yes	yes	no	no
	STAFF							

35	Doctors	Current	4	1	2	2	2	na	
		Sanctioned Posts	4	1	3	4	na	na	
		Vacancies	na	0	1	2	na	na	
		Absentees	na	0	na	na	na	na	
36	Staff Nurses	Current Strength	3	4	4	4	3	3	
		Sanctioned Posts	5	5	5	na	5	5	
		Vacancies	2	1	1	na	2	2	
		Absentees	na	0	na	na	na	na	
37	Auxiliary Nurse Midwives	Current Strength	2	3	3	3	5	5	
		Sanctioned Posts	4	4	4	na	9	9	
		Vacancies	2	1	1	na	4	4	
		Absentees	na	0	na	na	na	na	
38	Lab Technicians	Current Strength	1	0	1	1	1	1	
		Sanctioned Posts	1	0	1	1	na	1	
		Vacancies	na	0	0	0	na	0	
		Absentees	na	0	na	na	na	na	
39	Drivers	Current Strength	1	1	1	1	1	1	
		Sanctioned Posts	1	2	2	1	2	2	
		Vacancies	na	1	1	0	1	1	
		Absentees	na	0	na	na	na	na	
	Peons	Current Strength	4	0	1	2	5	5	
		Sanctioned Posts	4	3	2	2	5	5	
		Vacancies	na	0	1	0	0	0	
		Absentees	na	0	na	na	na	na	
	Ayahs	Current Strength	4	0	2	3	6	6	
		Sanctioned Posts	4	3	2	3	7	7	
		Vacancies	na	0	0	0	1	1	
		Absentees	na	0	na	na	na	na	
	Sweepers	Current Strength	na	0	3	3	4	4	
		Sanctioned Posts	3	3	3	3	5	5	
		Vacancies	na	0	0	0	1		
		Absentees	na	0	na	na	na	na	

	Dhobhis	Current Strength	contract basis	0	1	1	0	1
		Sanctioned Posts	1	1	1	1	1	1
		Vacancies	1	0	0	0	1	0
		Absentees	na	0	na	na	na	na
	CALACITY BUILDING							
	Number of training programmes in 2001-2002		7	3	4	5		3
	1	name of the programme	Laproscope	breast feeding	Measles vacination	Wase mgmt		Breast feeding
		Location	H siddaiah	na	IPP	IPP Training Center		HSRH
		Duration	1 month	na	2 days	2 days		nc
		Periodicity	na	na	na	na		na
		Staff trained	doctors	Zonal medical officers and zonal staff members	doctors	doctors		na
	2	name of the programme	Rabies	Rabies	Record Maintenance	Waste mgmt		cancer
		Location	MOH office	na	IPP	Training Center		na
		Duration	1 day	na	1 day	2 days		na
		Periodicity	na	na	na	na		na
		Staff trained	doctors	Zonal medical officers and zonal staff members	doctors	staff nurse		na
	3	name of the programme	TB	RNTPC	RNTCP	Maint of cards/referrals obstetric emergencies		ISO standard workshop or endoscopic surgery
		Location	NIT	na	na	Training Center		na
		Duration	5 days	na	na	2 days		na
		Periodicity	na	na	na	na		na
		Staff trained	ANM and staff doctor	Zonal medical officers and zonal staff members	na	staff nurse		na

	4	name of the programme	Breast feeding	0	Aids Awareness	HIV/Aids Training		endoscopic surgery	
		Location	SRMH and MOH	0	na	VVH		na	
		Duration	7 days	0	na	2 days		na	
		Periodicity	na	0	na	na		na	
		Staff trained	doctors	0	na	doctors		na	
	5	name of the programme	Hepatitis	0		RNTCP		nc	
		Location	SRMIT	0		NTI		na	
		Duration	1 day	0		1 day		na	
		Periodicity	na	0		na		na	
		Staff trained	Staff nurses, doctors	0		doctors		na	
	6	name of the programme	Cancer	0					0
		Location	Ulsoor	0					0
		Duration	1 day	0					0
		Periodicity	na	0					0
		Staff trained	doctors, staff nurses	0					0
	7	name of the programme	Accounts	0					0
		Location	MOH office	0					0
		Duration	2 days	0					0
		Periodicity	na	0					0
		Staff trained	doctors	0					0
	8	name of the programme		0					0
		Location		0					0
		Duration		0					0
		Periodicity		0					0

		Staff trained		0					0
	9	name of the programme		0					0
		Location		0					0
		Duration		0					0
		Periodicity		0					0
		Staff trained		0					0
	10	name of the programme		0					0
		Location		0					0
		Duration		0					0
		Periodicity		0					0
		Staff trained		0					0
	Number of training programmes in 2002-2003		4	4	5	1	3	3	
	1	name of the programme	MTP training	Breast feeding,Rabies & RNTPC	HRD	Hepititis B	Breast feeding	laproscopic	
		Location	SRMH	na	Koramangala	Dasappa Hospital	JJRN Referral Hospital	HSRH	
		Duration	1 month	na	3 days	2 days	1/2 day	na	
		Periodicity	na	na	na	na	na	na	
		Staff trained	doctors	Zonal medical officers and zonal staff members	doctors	doctors	Doctors,nurses,Technicians&others	doctors,staffs &ayahs	
	2	name of the programme	House surgery	laproscopic sterilisation	Hepatitis B vaccination		Cancer	MTP	
		Location	SRMH	na	MOH Office		na	HSRH	
		Duration	1 month	na	2 days		1 day	na	
		Periodicity	na	na	na		na	na	

		Periodicity	na	na	na		na	na
		Staff trained	doctors	Zonal medical officers and zonal staff members	doctors		Doctors	doctors
	3	name of the programme	STN training		Dengue fever workshop		Laproscopic training	TB
		Location	SRMRH		IMA		Siddaiah Hospital	HSRH
		Duration	nc		1 day		na	na
		Periodicity	na		na		na	na
		Staff trained	nc		doctors		na	doctors
	4	name of the programme	HIV					
		Location	MOH office					
		Duration	3 days					
		Periodicity	na					
		Staff trained	doctors					
	5	name of the programme						
		Location						
		Duration						
		Periodicity						
		Staff trained						
	6	name of the programme						
		Location						
		Duration						
		Periodicity						

		Staff trained						
	7	name of the programme						
		Location						
		Duration						
		Periodicity						
		Staff trained						
	8	name of the programme						
		Location						
		Duration						
		Periodicity						
		Staff trained						
	9	name of the programme						
		Location						
		Duration						
		Periodicity						
		Staff trained						
	10	name of the programme						
		Location						
		Duration						
		Periodicity						
		Staff trained						

FINANCIAL								
Salaries Budget	2001-2002	1803420	na	na	na	na		1987285
	2002-2003	1803420	na	na	na	na		2187285
Maintenance Budget – Equipment	2001-2002	na	na	na	na	na	na	
	2002-2003	na	na	na	na	na	na	
Maintenance Budget – Building	2001-2002	na	na	na	na	na	na	
	2002-2003	na	na	na	na	na	na	
Drugs Budgets	2001-2002	na	na	na	na	na	na	
	2002-2003	na	na	na	na	na	na	
Equipment Budget	2001-2002	na	na	na	na	na	na	
	2002-2003	na	na	na	na	na	na	
T[illegible]g Budget	2001-2002	na	na	na	na	na	na	
	2002-2003	na	na	na	na	na	na	
Fuel and Vehicle Budget	2001-2002	na	na	na	na	na	na	
	2002-2003	na	na	na	na	na	na	
Laundry Budget	2001-2002	na	na	na	na	na	na	
	2002-2003	na	na	na	na	na	na	
C[illegible]cted Services Budgets	2001-2002	na	na	na	na	na	na	
	2002-2003	na	na	na	na	na	na	
Miscellaneous Expenditure Budget	2001-2002	na	na	na	na	na		21860
	2002-2003	na	na	na	na	na	na	
Total User Fees	2001-2002	27800	na	39270	na	na		127400
	2002-2003	33970	na	28560	na	na		78050

	OUTPUT							
	Number of deliveries: Normal	2001 - 2002	980	2097	869	8550	1523	1398
		2002-2003	530	1410	385	10980	1142.4	576
	Number of deliveries: Assisted	2001 - 2002	20	2	46	42	435	0
		2002-2003	29	2	35	156	396	0
	Number of deliveries: Cesarean	2001 - 2002	1044	49	86	0	75	493
		2002-2003	1000	32	85	516	93.6	197
	Number of Family Welfare Procedures							
	Female Sterilizations	2001 - 2002	1044	1292	526	2484	711	1608
		2002-2003	1000	657	263	5592	524.4	513
	Male Sterilizations	2001 - 2002	0	4	0	0	0	na
		2002-2003	0	0	0	0	0	na
	IUCD Procedures	2001 - 2002	194	364	154	858	278	452
		2002-2003	160	192	76	1356	214.8	162
	Oral Pills Prescribed	2001 - 2002	80	188	0	0	140	na
		2002-2003	100	165	0	0	163.2	na
	Number of high risk pregnancies detected during labor	2001 - 2002	156	96	150	2550	435	493
		2002 - 2003	140	140	100	3336	396	205
	Number of high risk pregnancies detected during ANC (ante natal care)	2001 - 2002	40	120	190	1140	840	418
		2002 - 2003	45	70	170	2400	672	400
	Number of immunizations against measles	2001 -	480	1579	220	1572	697	480
		2002 -	360	684	190	1812	528	400
	Number of admissions (Inpatients)	2001 -	900	4135	950	11184	2423	2400
		2002 -	780	2251	600	18792	2166	2000
	Number of Outpatients treated (per day)	2001 - 2002	1030	8430	20	37.14	28.3	18000/year
		2002 - 2003	1000	4564	25	27.86	42	15000/year
	Number of admissions slips (Inpatients)	2001 -	600	600	na	3650	2423	2701
		2002 -	500	300	na	10950	2166	1600
	Number of admissions slips (Outpatients)	2001 -	2000	2050	na	33.57	10200	18000
		2002 -	1500	1147	na	9125	12600	15000
	Number of patients registered for post natal care	2001 -	1000	407	400	240	2423	960
		2002 -	800	249	450	360	2166	900
	Number of patients registered for ante natal care	2001 -	5800	6	1200	1395	2000	2696
		2002 -	4000	2	900	959	1788	1152
	Number of Medically	2001 -	250	336	126	88	0	420

	Terminated Pregnancies (MTP)	2002 -	200	180	60	190	0	300
	Number of complaints received	2001 -	60	407	0	0	nc	15
		2002 -	65	249	0	4	nc	10
	Number of cases referred to major hospitals (Referrals)	2001 -	30	6	50	125	129	36
		2002 -	30	2	25	78	50.4	25
	Number of prescription slips issued per month (Average)	2001 -	700	100	na	na	200	300
		2002 -	900	80	na	na	120	250
	Number of visits by the Supervisor	2001 -	2.5	3	12	5	13	24
		2002 -	2.5	2	12	40	12	24
	Number of visits by the health officer	2001 -	3	6	12	na	10	12
		2002 -	2	2	12	30	2.4	12
	Use of equipment as per requirements	2001 -	yes	yes	yes	yes	yes	yes
		2002 -	na	yes	yes	yes	na	yes
	OUTCOME							
	Number of maternal deaths	2001 -	0	0	1	0	0	4
		2002 -	0	0	0	0	0	2
	Number of neo natal deaths	2001 -	0	4	0	0	1	10
		2002 -	0	2	0	0	1.2	3
	Number of still births (at time of delivery after full term)	2001 - 2002	6	29	20	60	13	5
		2002 -	4	11	5	12	13.2	1
	Number of infant deaths (birth to one year)	2001 -	0	4	0	0	0	0
		2002 -	0	2	0	0	0	0
	Number of perinatal deaths (birth to 30 days)	2001 -	na	4	0	0	0	0
		2002 -	na	2	0	0	0	0
	Number of measles cases	2001 - 2002	na	0	0	0	0	0
		2002 -	na	0	0	0	0	0
	Number of deaths due to measles	2001 -	0	0	0	0	0	0
		2002 -	0	0	0	0	0	0
	Number of admissions to admission slips	2001 -	2500	na	0	11184	2423	0
		2002 -	2100	na	0	18792	2166	0
	Number of days with stock out of emergency drugs	2001 -	nc	inadequate	0	0	0	0
		2002 -	nc	inadequate	0	0	0	0
	Percentage of patients coming in for 3 post natal check ups	2001 -	na	na	40%	10%	70%	30%
		2002 -	na	na	30%	15%	80%	30%
	Percentage of patients registered for ante natal care prior to 12 weeks	2001 - 2002	na	30%	33%	na	80%	20%
		2002 - 2003	na	26%	21%	na	80%	20%
	Number of sterilization deaths	2001 -	0	0	0	0	0	0
		2002 -	0	0	0	0	0	0
	Total amount of user fees collected	2001 -	45000	77930	0	156960	35600	120000
		2002 -	10000	49430	0	550200	56580	78050
	Bed occupancy rate	2001 -	85%	101%	75%	86%	75%	145%

	2002 -	88%	98%	80%	88%	85%	140%
Availability of complaint redressal system		yes	yes	yes	yes	no	yes
Display board of essential drugs		yes	yes	yes	yes	yes	yes
EQUIPMENT							
Autoclave	Operative / Inoperative	op	op	op	op	op	op
	Since	na	na	2000	na	na	na
	AMC	na	no	yes	na	no	yes
Laryngoscope	Operative / Inoperative	op	op	op	op	inop	op
	Since		na	2001	na	1 yr	na
	AMC	na	no	yes	na	no	yes
Refrigerator	Operative / Inoperative	op	op	op	op	op	op
	Since	na	na	na	na	na	na
	AMC	na	no	no	na	no	yes
Generator	Operative / Inoperative	op	op	op	op	op	op
	Since	na	na	na	na	na	na
	AMC	na	no	no	na	no	yes
Ambulance	Operative / Inoperative	op	op	op	op	op	op
	Since	na	na	na	na	na	na
	AMC	na	no	no	na	no	yes
BP Apparatus	Operative / Inoperative	op	op	op	op	op	op
	Since	na	na	na	na	na	na
	AMC	na	no	no	na	no	yes
Instrument Sterilisers	Operative / Inoperative	op	op	op	op	op	op
	Since	na	na	na	na	na	na
	AMC	na	no	no	na	no	yes
Weighing Machine – Adult	Operative / Inoperative	op	op	op	op	op	op
	Since	na	na	na	na	na	na
	AMC	na	no	no	na	no	na

		Since	na	na	na	na	na	na
		AMC	na	no	no	na	no	na
	Baby Warmer / 200 watt lamp	Operative / Inoperative	op	op	op	op	inop	op
		Since	na	na	na	na	6mths	na
		AMC	na	no	no	na	no	na
	Boyle's Apparatus	Operative / Inoperative	op	op	op	op	op	op
		Since	na	na	na	na	na	na
		AMC	na	no	no	na	no	na
	Pulse Oximator	Operative / Inoperative	op	op	op	op	op	op
		Since	na	na	na	na	na	na
		AMC	na	no	no	na	no	na
	Hysteroscope	Operative / Inoperative	op	0	na	na	na	op
		Since	na	0	na	na	na	na
		AMC	na	0	na	na	na	na
	Time taken to fill up vacancies	2001 -	na	na	na	na	na	na
		2002 -	na	na	na	na	na	na
	Nurse Patient Ratio	2001 - 2002	1/170	na	1/10	1/9	1/2000/yr	1/50
		2002 - 2003	1/170	na	1/10	1/9	1/2000/yr	1/50
	Doctor patient Ratio	2001 - 2002	1/180	na	1/30	1/30	1/4000/yr	1/50
		2002 - 2003	1/180	na	1/30	1/25	1/4000/yr	1/50
	Waiting time for patient - Time between arrival at the center and being seen by the doctor	2001 - 2002	12.5	22.5	12.5	17.5	20 min's	30
		2002 -	10	22.5	na	15	20 min's	30
	Waiting time for patient - Time between registration and commencement of procedure	2001 - 2002	17.5	na	17.5	10	30 mins	17.5
		2002 -	15	na	na	10	30mins	17.5
	Cost of drugs per inpatient	2001 -	na	na	300	na	0	na
		2002 -	na	na	na	na	0	na
	Cost of drugs per outpatient	2001 -	na	na	50	na	0	na
		2002 -	na	na	na	na	0	na
	Cost per inpatient day	2001 -	na	na	70	na	0	na
		2002 -	na	na	na	na	0	na

	Cost per outpatient day	2001 -	na	na	15	na	0	na
		2002 -	na	na	na	na	0	na
	Utilisation of user fees	2001 -	10000	10000	no	na	5400	na
		2002 -	150000	16300	na	Rs 12532	8000	na
	Percentage of high risk cases among total deliveries	2001 -	10%	30%	13%	10%	435%	25%
		2002 -	13%	30%	13%	20%	230%	25%
	Number of complaints received to number of complaints	2001 -	0.2	1	1/0	0	0	na
		2002 -	20-30%	1	na	1	0	na
	EXPLANATORY INFORMATION							
	Number of patients below poverty line		65%	na	na	90%	100%	75%
	Inventory maintenance mechanism		available	available	available	available	available	available
	Store management mechanism.		available	available	available	available	available	available

CONTENTS

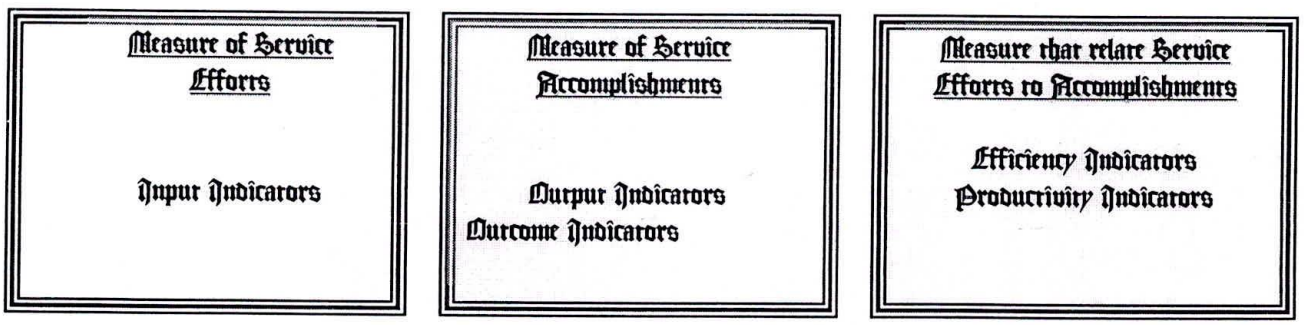
1.A PERFORMANCE INDICATORS – AN OVERVIEW

A holistic assessment of the performance of a government entity necessitates information, on both the source and use of resources as well as the efficiency and effectiveness of the activities being performed. This means that in addition to analyses of government budgets and financial statements, other measures of performance need to be used to estimate the quality of service delivery. Traditionally, the focus of government performance assessment has been on resource mobilization and usage, however a more complete framework of information would include not only measures of service efforts / resources, but service accomplishments and the relationship between efforts and accomplishments.

Performance measurement is essentially, an assessment of how well an organization (a government, in this case) performs when providing goods and services. Performance measurement can be made by developing measures or indicators of the volume, quality, efficiency and outcomes of public services.

Performance information provides the systematic framework, within which the administration elected representatives, and the public can identify and monitor the missions, goals and objectives of public services.

There are different ways of measuring performance; the PROOF campaign has adopted the methodology developed by the Governmental Accounting Standards Board (GASB), a five – indicator framework measuring service efforts and accomplishments[1]. These are:



[1] Refer Appendix A Introduction to Performance Measurements

1.B PERFORMANCE INDICATORS FOR EDUCATION

The PROOF campaign was launched on July 4th 2001with the objective of putting in a place a systematic structure of performance reporting along the lines of the private sector. The **PROOF** document, which defines this structure, has three principal components:

Public Record Of Operations and Finance

Financial Statements

- Revenue and Expenditure Statement
- Assets and Liabilities (form of Balance Sheet)

Performance Indicators

- Barometers of efficiency

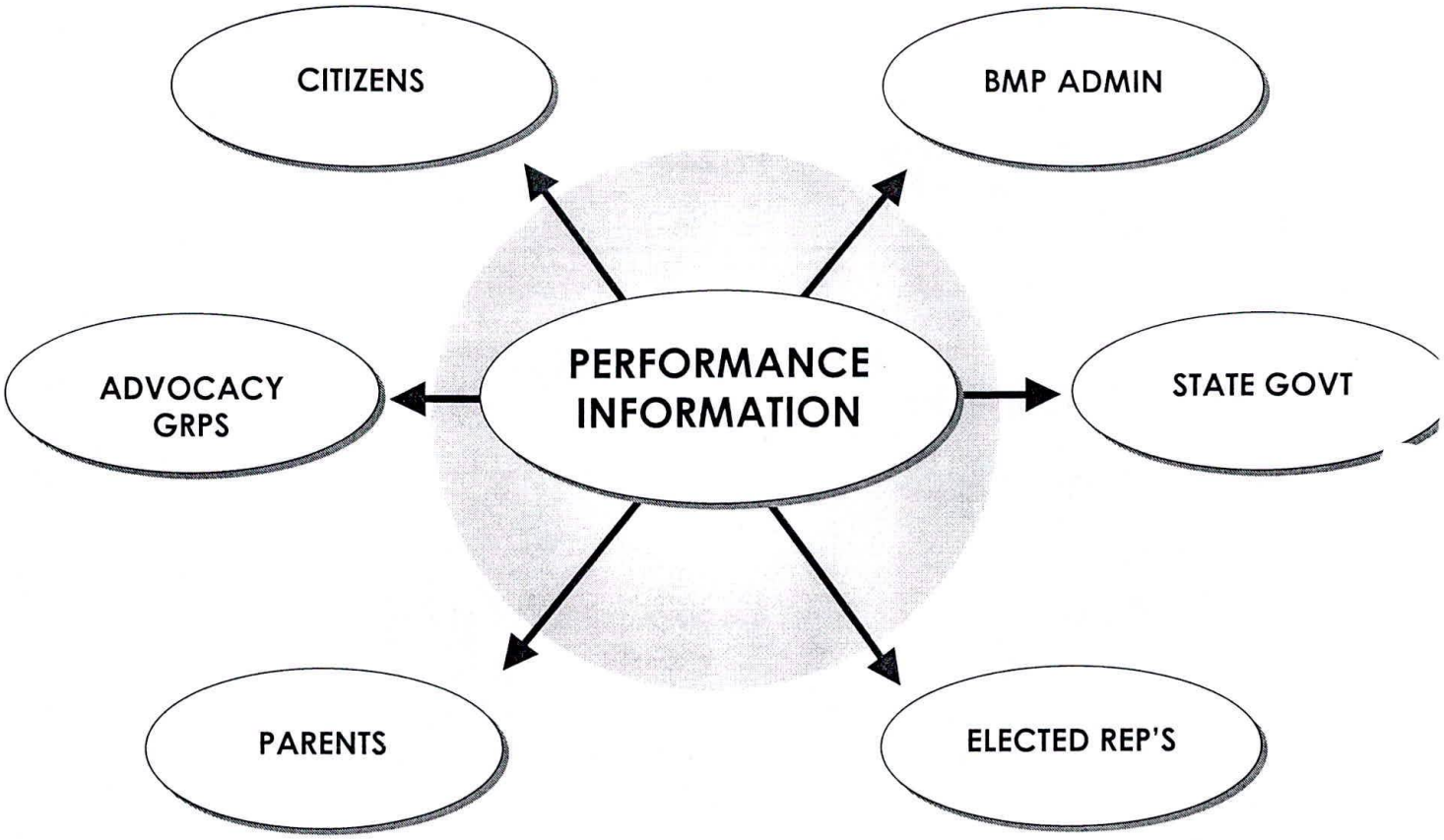
Management Discussion & Analysis

- Areas of focus, concern and priorities

Performance Indicators provide the scope for non-financial analysis thereby forming the crucial link between analyzing financial statements and management decision-making.

Over the past 4 months the PROOF campaign has been working with the education department of the Bangalore Mahanagara Palike to develop performance measures. A four-stage process has been identified for developing these measures:

1. **Identifying specific performance indicators for Education through an interactive process involving all stakeholders.**



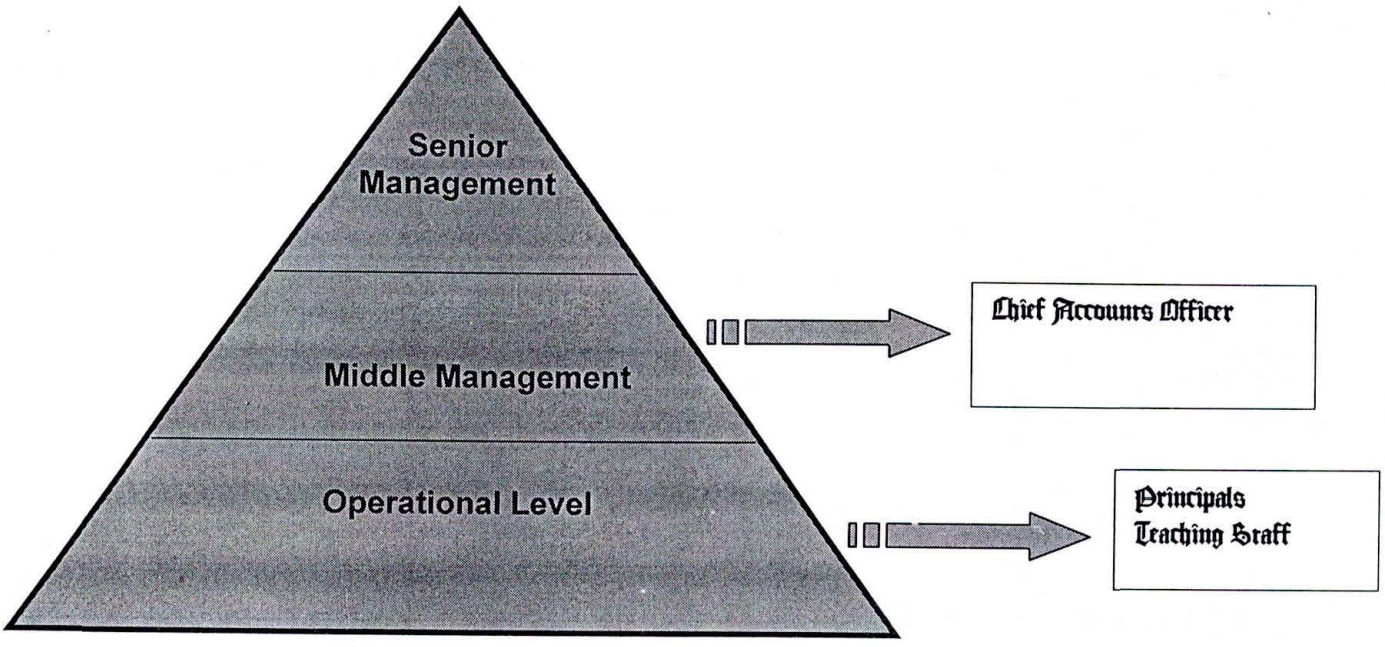
Over the course of two workshops 47 indicators were identified for the Education Department covering the **dimensions** of: Infrastructure, Teaching Staff, Accountability, Community Involvement, Subject Based, Financial, Other [2]

2. **Data collection from the schools of the city corporation** [3]

Secondary Schools	Primary Schools
32	11

[2] Refer Appendix B Performance Indicators for Education
[3] Refer Appendix C Sample Data Collection Form

Generators of Performance Information- Bangalore Mahanagara Palike



3. Data analysis based on the collected information [4]

Developing composite indices

Level 1
Composite Institution Index

Level 2
Composite Index for each Category of the five-indicator framework

Level 3
Composite Index for each dimension of the 6 dimensions

Level 4
Detailed Index for each of the 46 indicators identified

[4] Refer Appendix D Methodology of Data Analysis

4. Management Discussion using performance indicators as the basis for objective identification of successes and problem areas as well as specific solutions

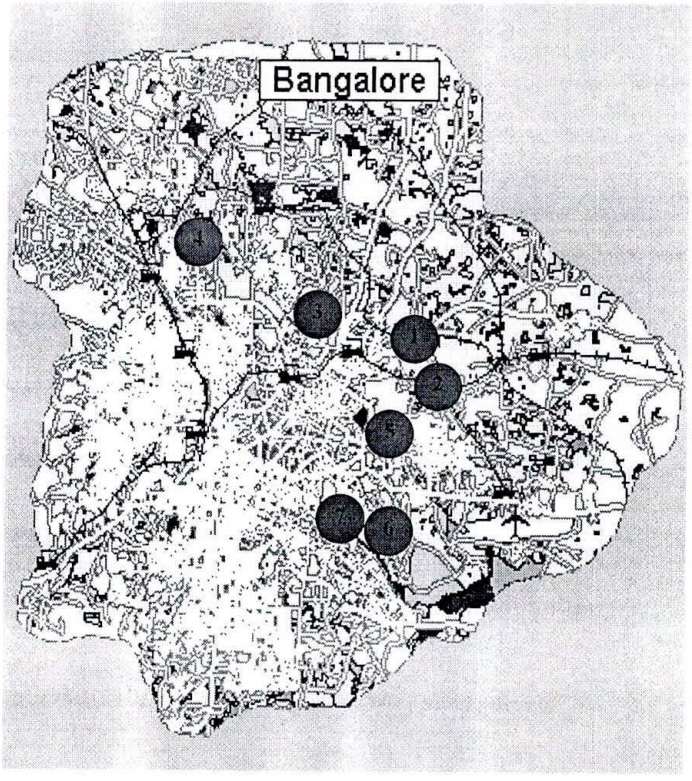
Using the framework of performance information the PROOF campaign along with the BMP has now identified five schools from among the 33 high schools of the city corporation, requiring immediate stakeholder intervention. Over the course of the next few months an action plan for intervention will be to improve service delivery in the 5 selected schools.

This kit provides information on the conceptual framework behind performance measurements as well as the action plan to facilitate stakeholder involvement in the identified schools.

2. SCHOOL INTERVENTION PROGRAMME – AKSHARA FOUNDATION

SEVEN SCHOOL PROFILE

1. Corporation Girls Primary School Narayan Pillai Street
2. Hafiza Corporation Higher Elementary School Broadway
3. Corporation Higher Elementary School Tasker Town
4. Corporation Higher Primary School Narappan Palya
5. Corporation Higher Elementary School Ulsoor
6. Corporation Higher Elementary School Austin Town
7. Corporation Higher Elementary School Neelasandra



Theme based intervention:

Theme IInfrastructure
Example: Physical Infrastructure such as Toilets, Playgrounds, Classrooms as well as Facilities such as Water Supply, Electricity and Security
Theme II
Community Involvement
Example: Formation and functioning of the SDMC
Theme III
Scholastic Outcomes
Example: Pass percentage, Minimum levels of learning , Attendance rates

APPENDIX A: INTRODUCTION TO PERFORMANCE MEASUREMENT

Government Accounting Standards Board (GASB) on Performance Measurement

What exactly is performance measurement?

Simply put, it is the assessment of how well an organization (a government, in this case) performs when providing goods and services. In other words, it is the process of asking and answering the questions above. Performance measurement produces information that can be used to help make decisions. Literally, it creates *measures* or *indicators* of the volume, quality, efficiency and outcomes of public services. Like the measure "miles per gallon" for an automobile, the products of performance measurement are yardsticks we can use to figure out if government is working well or poorly, or somewhere in between.

What is so important about performance measurement?

Governments should be accountable for the proper use of tax dollars and for providing the services citizens demand. Performance measures equip citizens with the information necessary to ensure accountability—to make sure that governments do what they are supposed to and achieve results that will improve people's lives.
Successful long-range planning requires reliable and useful data. Performance measures give governments the kind of information they need to make accurate assessments of what has happened and what needs are not being met, and to devise a plan to meet those needs. Governments also require this information to ensure their day-to-day operations run smoothly.

In general, performance measures aid persons in making decisions. For example, suppose you are planning to move and want to compare the schools in several districts. Will my child get enough attention from the teacher? Comparing each school's number of students per teacher might help to answer your question. Are the classes crowded? Check the student-to-classroom ratio. What about academic standards? Take a look at graduation rates, mastery test scores, or changes in student achievement as they progress through the school system. These and other measures give you the ability to make informed choices.

A municipal sanitation department could use performance measures to decide how to respond to rapid residential growth (and, therefore, increased demand for garbage collection). Two indicators could help the department determine if there is enough room in the trucks and if the workers have enough time to collect the additional garbage: Tons per truck shift (how much trash, on average, each truck collects each day) and the average number of hours it takes workers to complete a daily collection route. If the tons per truck are below capacity and routes are completed in less than a full day, then the extra trash could be collected by simply extending the routes. If the opposite is true, then the department will have to buy more trucks and hire more employees.

Performance information is needed for:

- Setting goals and objectives

- Planning program activities to accomplish these goals and objectives
- Allocating resources to programs
- Monitoring and evaluating results to determine if progress is being made toward achieving the goals and objectives, and
- Modifying program plans to enhance performance.

Performance measures organize information for use by the decision-makers engaged in those activities. Through the measurement, analysis, and evaluation of performance data, public officials can identify ways to maintain or improve the efficiency and effectiveness of activities and provide the public with objective information on their results.

What characteristics should performance information possess?

- Relevance
- Understandability
- Comparability
- Timeliness
- Consistency
- Reliability.

What role can citizens play in performance measurement?

Although more governments are engaging in performance measurement than ever before, according to a Government Accounting Standards Board (GASB) survey more than half still do not. Furthermore, only one out of five governments reports its performance measures to the public.

Citizens are the largest and most important audience for performance measures, but most do not have the opportunity to use such information to make decisions. Citizens should let their governments—state, city, county, village, school district—know that performance measures are crucial, and ask that they be collected and reported to the public. Citizens and governments should collaborate to identify what performance information is needed, to develop useful measures and to establish a system for collecting and reporting those measures.

TYPES OF PERFORMANCE INDICATORS WITH EXAMPLES

Input Indicators.
Government Accounting Standards Board (GASB) defines them as indicators that are designed "to report the amount of resources, either financial or other (especially personnel), that have

been used for a specific service or program. Input indicators are ordinarily presented in budget submissions and sometimes external management reports."
Examples of such indicators include total dollars spent, the number of teachers or nurses employed, or the number of garbage trucks or fire engines used.

Output/Workload Indicators.
These indicators report units produced or services provided by a program. Workload measures indicate the amount of work performed or the amount of services received.
For example, school graduation rates, number of patients treated in the emergency room, tons of garbage collected, or number of fires extinguished.

Outcome/Effectiveness Indicators.
These measures are designed to report the results (including quality) of the service. According to Paul D. Epstein, "effectiveness measurement is a method for examining how well a government is meeting the public purpose it is intended to fulfill. In other words, effectiveness refers to the degree to which services are responsive to the needs and desires of a community. It encompasses both quantity and quality aspects of a service."
Examples of outcome indicators are the change in students' test scores, change in the value of property lost due to crime, cleanliness ratings based on routine inspections describing a city's success (or lack thereof) at cleaning its streets or parks. To gauge its success, a fire department might track the number of fire-related deaths and injuries, or the dollar value of property lost to fire. A hospital might utilize mortality rates and the results of random patient surveys. A school district might collect information on the percentage of graduating students gainfully employed or continuing education two years after graduation.

Efficiency (and Cost-Effectiveness Indicators).
As Epstein defines them, *efficiency measurement* is a method for examining how well a government is performing the things it is doing without regard to whether those are the right things for the government to do. Specifically, *efficiency refers to the ratio of the quantity of the service provided (e.g., tons of refuse collected) to the cost, in dollars or labor, required to produce the service.* According to GASB, these indicators are defined as indicators that measure the cost (whether in dollars or employee hours) per unit of output or outcome.
Examples of *input-output* comparisons include annual cost per inmate in jail, cost per lane-mile of road repaired, and ratio of nurses to patients discharged.
Input-outcome measures include cost per inmate successfully rehabilitated, cost per lane-mile of road maintained in good or excellent condition, and cost per patient cured without remission.

Productivity indicators.
David N. Ammons defines productivity indicators as combining the dimensions of efficiency and effectiveness in a single indicator. For instance, whereas "meters repaired per labor hour" reflects efficiency, and "percentage of meters repaired properly" (e.g., not returned for further repair within 6 months) reflects effectiveness, "unit costs (or labor-hours) per effective meter repair" reflects productivity. The costs (or labor-hours) of faulty meter repairs as well as the costs of effective repairs are included in the numerator of such a calculation, but only good repairs are counted in the denominator--thereby encouraging efficiency *and* effectiveness of and by meter repair personnel.

Explanatory Information
In many cases, along with the above-mentioned indicators, some additional information is needed to make a sound judgment about service provision. GASB, for example, specifies

certain types of Explanatory Information for its suggested list of indicators for service efforts and accomplishments. GASB defines a variety of information about the environment and other factors that may affect an organization's performance on Service Efforts and Accomplishments indicators, for example weather conditions for road maintenance.

Explanatory information includes socioeconomic and other factors that are largely beyond the control of government, such as median household income, inflation, and annual inches of snowfall. It also covers factors within the government's control, like ratios of public employees to service recipients.

APPENDIX B: PERFORMANCE INDICATORS FOR EDUCATION

	INPUT	OUTPUT	OUTCOME	EFFICIENCY	PRODUCTIVITY	EXPLANATORY
INFRASTRUCTURE	- Number of toilets. - Number / Area of playgrounds. - Number of classrooms. - Height of the ceiling. - Availability of library. - Availability of electricity. - Availability of drinking water. - Availability of Laboratory. - Classroom furniture Tables Chairs - Classroom equipment Blackboards Chalk Dusters. - Teaching material Teacher guide Library Books Storage Area Globe Science Kit Maths Kit Musical Instruments Toys Art and Craft Material			- Number of children per classroom.		

TEACHING STAFF	- Number of teachers in the school. Full Time Part Time OOD - Average teacher salary. Junior Senior Head Master / Head Mistress - Number of teachers meeting pre-service qualification requirement. - Number of in-service skill training programmes.	- Teacher attendance rates.		- Pupil teacher ratio.		- Number of teachers teaching outside their primary subject area.
ACCOUNTABILITY		- Pass percentage. -Attendance rates by sex. -Completion of daily lesson plan -Completion of Programme of works - Minimum levels of learning (MLL) - Test scores	- Reduction in absenteeism rates.- - Reduction in Dropout Rate			

COMMUNITY INVOLVEMENT	- Existence of SDMC / SBC/ or PTA.	- Number of meetings. - Number of parent attendees per meeting. - Number of OTHER nominees attending. - Availability of information kit. - Availability of minutes book. - Availability of complaints book.		- Number of complaints received to Number of complaints redressed.		
SUBJECT BASED	- Number of language teachers. - Number of teachers for other subject					
FINANCIAL	- Total expenditure on Infrastructure Salary Equipment.			- Fees per student. - Cost per student.		
OTHER		- Distribution of supplies Uniforms Text Books Notebooks - Number of extra curricular activities.		- Number of Transfer certificates (TC) applied for to Number of Transfer certificates (TC) issued	- Cohort compliance rates.	- Number of students attending only for mid day meals. - Immunisation. - Number of first generation school goers.

APPENDIX C: SAMPLE DATA COLLECTION FORM

DATA COLLECTION FORM FOR PERFORMANCE INDICATORS

SECONDARY SCHOOLS.

GENERAL INFORMATION

Name of School: _____

Name of Principal: _____

Location: _____

Phone No: _____

Ward Number: _____

Year of Inception: _____

Number of sections per class: _____

Medium of Instruction: _____

PERFORMANCE INDICATOR INFORMATION

I. INPUTS

These are indicators that are designed to report the amount of resources, either financial or other (especially personnel), that have been used for a specific service or program.

INFRASTRUCTURE

SCHOOL LEVEL

- Number of toilets:

Male	
Female	
Common	

- Availability of safe and adequate drinking water for the children: Y / N
- Number of playgrounds:_____
- Total Area of the playground:_____
- Number of Buildings:
- Number of classrooms:_____
- Availability of library Y / N
- Availability of laboratories

  Science Y / N

  Computer Science Y / N
- Availability of electricity Y / N

CLASSROOM LEVEL

	Class 8	Class 9	Class 10
▪ Area of the classroom			
▪ Height of the ceiling			
▪ Are the Number of Tables or Writing Stations adequate	Y / N	Y / N	Y / N
▪ Are the Number of Chairs or Benches Adequate	Y / N	Y / N	Y / N
• Blackboard	Y / N	Y / N	Y / N
▪ Chalks	Y / N	Y / N	Y / N
▪ Dusters	Y / N	Y / N	Y / N
▪ Teacher's Guide	Y / N	Y / N	Y / N

Junior	
Senior	
Head Master	

CLASSROOM LEVEL

		Class 8	Class 9	Class 10
▪ Number of Teachers	Full Time			
	Part Time			
	OOD (Off on Duty)			

COMMUNITY INVOLVEMENT

SCHOOL LEVEL

- Does the school have an SDMC (School Development and Monitoring Committee).

SUBJECT BASED

SCHOOL LEVEL

- Number of language teachers in the school.

Hindi	
Kannada	
Tamil	
Sanskrit	
Urdu	
Other	
Total	

▪ Science Kits	Y / N	Y / N	Y / N
▪ Math's Kit	Y / N	Y / N	Y / N
▪ Globe / Atlas	Y / N	Y / N	Y / N
▪ Library Books	Y / N	Y / N	Y / N
▪ Musical Instruments	Y / N	Y / N	Y / N
▪ Storage area for material	Y / N	Y / N	Y / N
▪ Sports Equipment	Y / N	Y / N	Y / N
▪ Art and Craft Material.	Y / N	Y / N	Y / N

TEACHING STAFF

SCHOOL LEVEL

- Number of teachers meeting pre-service qualification requirements.
- Number of annual in-service skill training programmes in:

1999-2000: _____

2000-2001: _____

2001-2002: _____

2002-2003: _____

- Average teacher salary (Rs. per month) (Gross)

- Number of teachers for each other subject.

English	
Maths	
Social Studies	
Science	
Total	

FINANCIAL

SCHOOL LEVEL

- Annual expenditure on physical infrastructure such as buildings and furniture.

- Annual expenditure on other teaching equipment.

- Annual expenditure on teachers salary.

- Annual expenditure on salary of administrative staff.

II OUTPUT

These indicators report units produced or services provided by a program.

A. TEACHING STAFF

SCHOOL LEVEL

- Teacher attendance:

Regular	Irregular

- No of vacancies:
-

(Number of Sanctioned Posts - Number of teachers)

B. ACCOUNTABILITY

CLASSROOM LEVEL

			Class 8	Class 9	Class 10
▪ Pass percentage	1999 – 2000	F			
		M			
	2000 – 2001	F			
		M			
	2001 – 2002	F			
		M			
	2002 – 2003	F			
		M			
▪ Enrollment by Sex	1999 – 2000	F			
		M			
	2000 – 2001	F			
		M			
	2001- 2002	F			
		M			
	2002 – 2003	F			
		M			

▪ Average attendance rates (%)	1999 – 2000	F			
		M			
	2000 – 2001	F			
		M			
	2001 – 2002	F			
		M			
	2002 – 2003	F			
		M			
▪ Are Minimum Levels of learning (MLL) attained?		Y / N		Y / N	Y / N
▪ Average test scores					
▪ Completion of Programme of works.		Y / N		Y / N	Y / N
▪ Completion of Daily lesson plan.		Y / N		Y / N	Y / N

F=Female M= male

C. COMMUNITY INVOLVEMENT

SCHOOL LEVEL

- Number of SDMC meetings per annum.
- Average number of parents attending SDMC meetings.
- Average number of other members attending SDMC meetings.
- Availability of minutes books during the SDMC meeting.
- Availability of a complaints register.

- Availability of SDMC information kit.

D. OTHER-

SCHOOL LEVEL

- Distribution of supplies (Per annum)

No of Uniforms Distributed:

No of Text books distributed:

No of Notebooks distributed:

- How many extra curricular activities does the school provide:

Music	
Games	
Debate / Public Speaking	
Crafts	
Yoga	
Drawing and Painting	
Others	

III OUTCOME

These measures are designed to report the results (including quality) of the service.

A. ACCOUNTABILITY

CLASSROOM LEVEL

			Class 8	Class 9	Class 10
Absenteeism rates (%)	1999-2000	F			
		M			
	2000-2001	F			
		M			
	2001-2002	F			
		M			
	2002-2003	F			
		M			
Drop out rates (%)	1999-2000	F			
		M			
	2000-2001	F			
		M			
	2001-2002	F			
		M			

Drop out rates (%)	2002-2003	F			
		M			

F=Female M=Male

IV EFFICIENCY

These measures are designed to report the ratio of the quantity of the service provided to the cost, in rupees or labor, required to produce the service.

A. INFRASTRUCTURE

SCHOOL LEVEL

- Number of children per classroom

B TEACHING STAFF

SCHOOL LEVEL

- Pupil teacher ratio.

CLASSROOM LEVEL

	Class 8	Class 9	Class 10
▪ Pupil teacher ratio.			

C COMMUNITY INVOLVEMENT

SCHOOL LEVEL

- Number of complaints received to number of complaints redressed.

D SUBJECT BASED

SCHOOL LEVEL

- Number of language students to number of language teachers.

E FINANCIAL

SCHOOL LEVEL

- Fees per student.
- Cost per student

F OTHER

SCHOOL LEVEL

- Number of Transfer certificates applied for to number of Transfer Certificates issued.

V. PRODUCTIVITY

- Cohort compliance rates

Average Age of entry at class Eight:

Average Age of exit at class Ten:

VI. EXPLANATORY INFORMATION

A TEACHING STAFF

SCHOOL LEVEL

- Number of teachers teaching outside their primary subject area.

B OTHER

SCHOOL LEVEL

- Number of first generation school goers
- Number of children immunised as per requirements.
- Number of students attending only for mid- day meals.

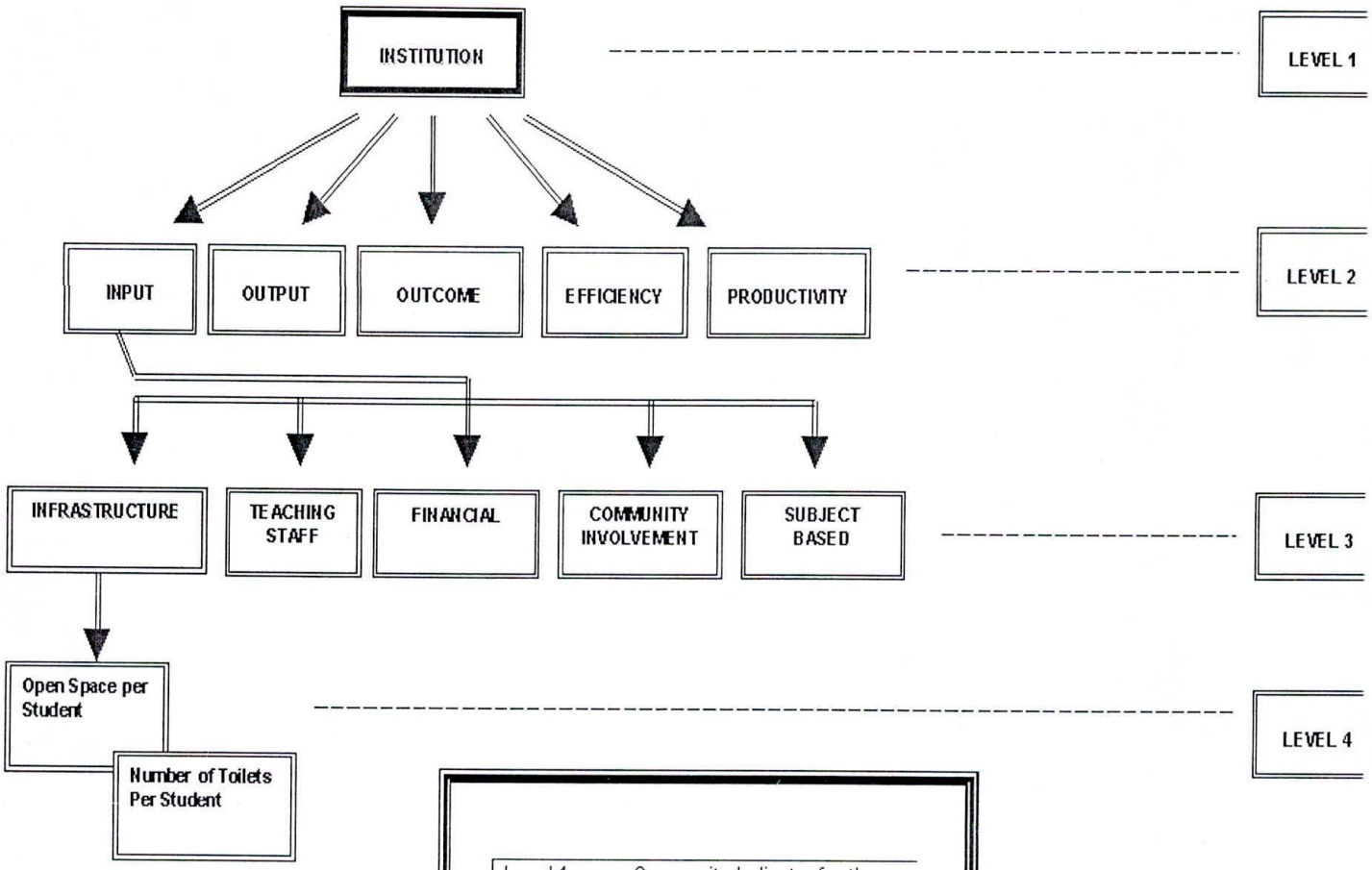
APPENDIX D: METHODOLOGY OF DATA ANALYSIS

SNAPSHOT OF PERFORMANCE INDICATORS ON EDUCATION

Dimension / **Category**	Infrastructure	Teaching Staff	Community Involvement	Accountability	Subject Based	Financial	Other	TOTAL
Input	7	6	1	-	2	2	-	**19**
Output	-	1	4	8	-	-	4	**17**
Outcome	-	-	-	2	-	-	-	**2**
Efficiency	1	1	1	-	-	3	1	7
Productivity	-	-	-	-	-	-	1	-
TOTAL	**9**	**8**	**6**	**10**	**2**	**5**	**6**	**46**

- The table above represents the break down of identified Performance Indicators for Education across the five-indicator framework.
- These five indicators are categorised as Input, Output, Outcome, Efficiency, and Productivity indicators.
- The identified Performance Indicators for Education fall under seven broad dimensions, namely Infrastructure, Teaching Staff, Community Involvement, Accountability, Subject Based, Financial and Other.
- The values in the cells represent the number of Performance Indicators for each Category and Dimension. For example there are 8 Performance Indicators, which fall under the classification Input Infrastructure.

LEVELS OF INDICATORS



Level 1	Composite Indicator for the Institution.
Level 2	Composite Indicator for each Category.
Level 3	Composite Indicator for each dimension.
Level 4	Detailed Indicator for each dimension.

REFERENCE TABLE
Conversions Formulas and Weight Assignments.

	Dimension	Level 4 Indicator	Conversion Formula	Score	Weight for Level 3	Weight for Level 2	Weight for Level 1
INPUT	Infrastructure	- Number of toilets	Number of toilets / Prescribed Value * 100	50	75%	25%	10%
		- Open space per student (OSS)	OSS / Prescribed value * 100	50	25%		
	Teaching Staff					35%	
	Subject Based					15%	
	Community Involvement					10%	
	Financial					15%	
TOTAL					**100 %**	**100 %**	
OUTPUT							10%
OUTCOME							20%
EFFICIENCY							25%
PRODUCTIVITY							35%
TOTAL							100 %

- Level 4 Indicators represent detailed indices for each dimension falling under a category. Forty-six Level 4 indicators have been identified for Education.
- The conversion formula forms the basis for converting the level 4 Indicator into a score.
- Level 3 weighting assigns weights to each Level 4 indicator within a dimension according to its perceived importance within the dimension.

- Level 2 weighting assigns weights to each Dimension within a category according to its perceived importance within the Category.
- Level 1 weighting assigns weights to each Category in the five-indicator framework according to its perceived importance.

EXAMPLE: CALCULATION OF WEIGHTED INDICES

	Dimension	**Level 4 Indicator**	**Score**	**Level 3** (Score * Level 3 Weight)	**Level 2**	**Level 1**
INPUT	Infrastructure	- Number of toilets	50	50 * 75%	Composite Input Infrastructure Index * Level 2 Weight 50 * 25%	Composite Input Index * Level 1 Weight 26.75 * 10%
		- Open Space Per student	50	50 * 25%		
				Composite Input Infrastructure Index 37.5 + 12.5 = 50		
	Teaching Staff				Composite Input Teaching Staff Index * Level 2 Weight 25 * 35%	
				Composite Input Teaching Staff Index		
	Subject Based				Composite Input Subject Based Index * Level 2 Weight 10 * 15%	
				Composite Input Subject Based Index.		
	Community Involvement				Composite Input Community Involvement Index * Level 2 Weight 10 * 10%	
				Composite Input Community Involvement Index.		
	Financial				Composite Input Financial Index * Level 2 Weight. 20 * 15%	
				Composite Input Financial Index.		
					Composite Input Index 12.5 + 8.75 + 1.5 + 1 + 3 = 26.75	

APPENDIX E: PERFORMANCE INDICATORS - DESCRIPTION SHEET

INPUT	DETAILS	RAW SCORE	CONVERSION
INFRASTRUCTURE			
Number of Students per toilet.	Number of Students / Number of Toilets.	Ratio	Median / Ratio* 100)
Open space per student	Area of the Play Ground / Number of Students	Ratio.	Ratio / Median* 100
Room space per student	(Total Class room Area * Number of class Rooms) / Number of Students.	Ratio.	Ratio / Median* 100
Height of the Ceiling	Gives the height of the ceiling in feet.	Height in feet	Ratio / Median* 100
School facilities	This indicator takes into account availability of water, library, lab facilities and electricity.	Four point scale score.	Score / 4 * 100
Classroom Furniture	This indicator takes into account the availability of Writing Tables and Benches.	Score on a two point	Score / 2*100
Teaching Equipment.	This indicator takes into account teaching material such as availability of blackboards, chalks, books, maths and science kits etc.	Score on a 12-point scale.	Score / 12 *100
TEACHING STAFF			
Number of teachers meeting pre service qualification requirements	Number of teachers meeting pre service requirements. Qualitative response.	Score on a one point scale	Score / 1 *100
Total. Number of training Programmes	The total number of training programmes over the past four years.	Number.	Number / Median * 100
Average Teacher salary Junior	Teachers Salary for Junior Level, if a range is given the average was taken.	Salary	Salary / Median * 100
Average Teacher salary Senior	Teachers Salary for Senior Level, if a range is given the average was taken.	Salary	Salary / Median * 100
Salary of HM	Teachers Salary for HM Level, if a range is given the average was taken.	Salary	Salary / Median * 100
Number of OOD teachers.	OOD - Off on Duty. Includes teachers on the pay role of the school on deputation to another school.	Number.	Median / Number *100

COMMUNITY INVOLVEMENT			
Does the School have an SDMC / SBC or PTA	The indicator estimates the number of parent teacher interactions.	Number	Number / Median * 100
SUBJECT BASED			
Number of Language teachers in the school.		Number	Number / Median * 100
FINANCIAL			
Total Salary Expenditure	Annual Expenditure on salary of teachers and administrative staff.	Number	Number / Median * 100
OUTPUT			
TEACHING STAFF			
Teacher attendance.	Qualitative Response.	One point scale score	Score / Median * 100
COMMUNITY INVOLVEMENT			
Number of SDMC meetings per annum.	Number of parent teacher meetings in a year.	Number	Number / Median * 100
Average percentage of parents attending SDMC meetings.		Percentage	Percentage / Median *100
Average Number of other members attending SDMC meetings.		Number	Number / Median * 100
Material For SDMC meetings.	This includes information on availability of complaints register, minutes book and information kit. Qualitative response.	3 point scale Score.	Score / 3 *100
ACCOUNTABILITY			
Class ten pass percentage 2001-2002		Percentage	Percentage / Median *100
Average Pass Percentage Class Ten	Average pass percentage over the past three years.	Percentage	Percentage / Median *100
Gap between Pass Percentage in Class Eight / Nine and Class Ten	Difference between the average pass percentage in class ten and average pass percentage for class eight and nine.	Percentage.	Median / Percentage * 100
Total Enrollment in 2002-2003		Number	Number / Median * 100
Average attendance for Class 8, 9 and 10 in 2002 – 2003		Percentage	Percentage / Median *100
Minimum levels of learning (MLL)	MLL as perceived by the principal for class eight nine and ten.	3 point scale Score.	Score / 3 *100

Average test Scores	Average test score for class 8, 9 and 10.	Percentage.	Percentage / Median *100
Completion of Programme of Works:	Qualitative response.	1 point scale score	Score / 1 * 100
Completion of Daily Lesson plan	Qualitative response.	1 point scale score	Score / 1 * 100
OTHER			
Distribution of Supplies Number of uniforms		1 Point scale score	Score / 1*100
Distribution of Supplies Number of textbooks.		1 point scale score	Score / 1*100
Distribution of Supplies Number of notebooks.		1 point scale score	Score / 1*100
Extra Curricular activities.	Number of extra curricular activities provided by the school	Seven Point Scale score.	Score / 7 *100
OUTCOME			
ACCOUNTABILITY			
Average Drop Out Rates	Average absenteeism rates for class eight nine and ten over the past four years.	Percentage.	Median / Percentage * 100
EFFICIENCY			
INFRASTRUCTURE			
Number of Children per classroom	Number of children / Number of classrooms.	Ratio.	Ratio / Median *100
TEACHING STAFF			
Pupil teacher ratio	Number of teachers / Number of students.	Ratio.	Ratio / Median *100
COMMUNITY INVOLVEMENT			
Number of complaints received to number of complaints redressed	Qualitative Response.	Ratio.	Ratio / Median *100
FINANCIAL			
Fees per Student Regular	Rs per student per annum.	Fees	Fees / Median * 100

Fees per Student SCST	Rs per SC /ST student per annum.	Fees	Fees / Median * 100
Salary Cost per student.	Total Salary Expenditure / Number of students.	Ratio	Median / ratio * 100
PRODUCTIVITY			
OTHER			
Age of entry at class eight	Average age should be 13	Number	Number / 13 * 100
Age of entry at class ten	Average age of exit should be 16.	Number	Number / 16 * 100

COMMUNITY HEALTH AND EPIDEMIOLOGY

1.	**Concepts of Health** • Definitions : Health, Community Health, Public Health • Determinants of Health • Primary Health Care – Alma Ata Declaration • Causation of diseases • Indices in the measurements of health • Community participation, Organisation and Mobilization for Health	
2.	**Environment and Health** • Physical, biological, social, economic and cultural environment • Water : safe drinking water; sources of water • Sanitation; waste disposal • Pollution : air, water, soil • Housing • Pesticides	
3.	**Health Promotion** • Health education • Healthy lifestyles. Control of use of alcohol, tobacco, addiction, forming drugs • School health	
4.	**Communication for Health** • Individual, group, mass • Media – folk, electronic, print	
5.	**Food and Nutriton** • Food security; nutrition security • National nutrition policy • Malnutrition. Anaemia. • Food hygiene. Safety of food. Food adulteration.	

6.	**Occupational Health** • Physical, chemical, biological and social hazards • Effects of heat, humidity, cold, radiation, noise on health • Accidents; injuries • Factories Act. Employees State Insurance Act	
7.	**Medical Sociology** • Socio-cultural factors related to health and disease • Rural and urban communities; impact of urbanization	
8.	**Health Care Facilities** • Public Sector : Primary Health Centres, sub-centres, Community Health Centres, Sub-district and District Hospitals, Teaching Hospitals, Speciality Hospitals • Private Sector • Voluntary Sector	
9.	**National Health Policy** • Health Systems in India • Health Committees • National Health Policy – 2002	
10.	**Vital Statistics** • Vital statistics and surveys • Socio-economic indicators • Disparities in health	

11.	**Epidemiology** • Definition; concepts • Sources of epidemiological data • General principles and methods of epidemiology • Communicable and non-communicable diseases and their control • Vaccines and vaccine preventable diseases. Universal Immunization programme. • Water related diseases • Vector borne diseases	
12.	**Epidemiology of selected diseases** • Acute Respiratory infections • Diarrhoeal diseases • Malaria • Tuberculosis • HIV / AIDS • National Disease Control / eradication programmes.	
13.	**Health of the Disadvantages** • Empowerment • Child Health • Health of the Aged • Women's Health • Persons with Disabilities	
14.	**Rational Use of Drugs** • Essential Drugs • Drug Patents. Cost of drugs.	
15.	**Research in Health and Diseases** • Why Research? • How to carry out research in communities?	

16.	**Medical Ethics** • Ethical guidelines	
17.	**Poverty and Health** • Ill-health and poverty • Poverty alleviation	
18.	**Health Planning** • Planning for health. Five Year Plans and Health • Decentralisation. Panchayati raj	
19.	**Health Financing** • Expenditure on health • Public Health Expenditure • Budget allocation and utilization	
	PRACTICALS • Collection of Water and stool samples for microbiological examination and evaluation • Calculation of health indices. • Problem solving exercises • Spotter – nutrition, environmental health, entomology, helminthes, parasites	
	Scheme of Examination	
	Books	