VOLUNTARY HEALTH ASSOCIATION OF KARNATAKA

Minutes of the meeting held on Saturday August 14, 1993 at the Board Room, St.Martha's Hospital, Bangalore to work out the details of bringing out the Report - State of Karnataka's Health.

Meeting started at 12.00 noon,

Members present

Mr.Alok Mukhopadhyay
Dr.C.M.Francis
Dr.S.P.Tekur
Dr.Tharien - President, TNVHA
Dr. S.Pruthvish
Dr. H.Sudarshan
Dr. Upendra Shenoy
Mr. S.M.Subramanya Setty
Dr. Sudha Xirasagar - ISHA
Ms. T.Neerajakshi
Mr. Ramappa C.Hadli

After self introduction Mr.Alok Mukhopadhyay, Executive Director of VHAI briefed about the context of the Meeting. He recalled the offer that came from the Government of Karnataka to bring out a report of the 'State of Karnataka's Health' on the occasion of the releasing ceremony of the 'State of India's Health', which was held on 30th May 1993 at St.John's Medical College, Bangalore. He appreciated that VHAK Board in consultation with VHAI had committed to take up this endeavour. He proposed to offer his experience, expertise and help to VHAK.

Mr.Alok Mukhopadhyay shared that VHAI Board was positive when the same was discussed at the Meeting. He said that it should be a participatory process. Once the contents of the report are finalised, resource persons may be identified accordingly. He suggested that a core group may be formed and two young Researchers or Research Assistants may be appointed for 6 months to help in collecting the various data and resource materials to be provided to the authors and also to conduct pilot studies (sample survey). The committee agreed for the same.

Dr.C.M.Francis stated that the Commissioner & Secretary to the Dept. of Health & Family Welfare Services, Government of Karnataka had earlier suggested that VHAK should work out a Health Policy for Karnataka with district planning. It was suggested that the two could be combined: State of Karnataka's Health, followed by a Health Policy for Karnataka State. This was accepted.

It was opined to discuss

a) Content
b) Who is willing to take up what including persons who are not present
c) Editorial Board
d) Budget

The Committee discussed about the various Resources Centres from where reliable materials may be collected.

Mr.Alok Mukhopadhyay stated that once the materials are pooled and authors are identified Dr.Almas Ali who has rich experience and had given enough time in preparing the State of India's Health Report could come over to help in processing and analysing.

An Editorial Committee comprising of the following personnel was set up:

Dr.C.M.Francis
Dr.H.Sudarshan
Dr.S.P.Tekur
Ms.T.Neerajakshi
Dr.Sudha Xirasagar

The Contents and Resource persons proposed were as follows:

1. Food: This would include food in the wider perspective including food production, distribution, availability, accessibility and nutrition.

(I)(14)

Dr.Vanaja Ramprasad
Mr.Somashekar Reddy
Dr.Almas Ali
Dr.M.K.Vasundhara

It was suggested to formulate sub-topics so that the chapter becomes comprehensive.

2. Environment & Health

(III)(87)

Mr. Yellappa Reddy
Dr. S.R.Hiremath
Mr. Panduranga Hegde
Dr. S.V.Rama Rao
Dr. Nag
Dr. Kusuma

3. Health Systems & Services (Govt., Voluntary Organisations & Private sector)

Dr.S.P.Tekur
Dr.G.V.Nagaraj
Prof. Shanmugam - IIM
Dr.Sudha Xirasagar
AIDS and STD may be incorporated under this heading

4. Indigenous Systems of Medicine (Alternative systems)

Emphasis will be on systems more prevalent in Karnataka

Dr.Anantharaman, Dr.Upendra Shenoy

5. Family Welfare & MCH

Dr.Sudha Xirasagar, Dr.G.V.Nagaraj

6. Health Education (including Health manpower development)

Dr.Jayashree Ramakrishna | N I M H A N S
Mr.S.M.Subramanya Setty |
Dr. Uma Sridharan

7. Medical and Nursing Education

Community Health Cell

8. Health Information system

9. Women & Health

Dr. Uma Sridharan
Mrs. Anthya Madiath
Mrs. Srilatha Batliwala
Samatha (Organisation)

10. Health Research

Dr. Saraswathy Ganapathy
Dr. S.V.Rama Rao

11. Health Financing (Including Foreign Funding and Family expenditure)

The relevant resource materials may be collected from
IIM, ISEC, NIMHANS, ISHA, IPP
Mrs. Shoba Raghuram - HIVOS, Dr.Bhatia - IIM

12. Legal Issues

Mr.M.K.Ramesh

13. Disabilities

Dr. Maya Thomas | Action Aid
Dr. S.Pruthvish |
Ms. Indumathi Rao

14. Mental Health (XIX). (401).

Dr.R.Srinivasamurthy, Dr.Mohan Isaac

15. Panchayat Raj

Prof. B.K.Chandrashekar, Mr.R.L.Kapur

16. Health Awareness

It was felt that action to attain and maintain health has to be taken by the individual, family and community. This would depend to a large extent on health awareness of the people. A chapter on it would be appropriate.

The Editorial Committee will consider other areas also, as considered appropriate. It was suggested that the actual expenditure and State Budget (in % age) approportioned to Health by the Karnataka Government, expenditures of various groups and particularly the family towards Health may be elucidated by collecting data and conducting sample (pilot) studies, where the data are not availalbe.

It was opined that the draft should be ready by December. The members expressed doubts whether this can be done in such a short time. An effort will be made to stick to the target.

It was expected that there may be 22-23 chapters. The volume of the report may be ranging from 300 to 350 pages.

BUDGET: It was estimated that the expenditure may come up to Rs.1,50,000/-. VHAI, New Delhi would take up the responsibility of art work, illustrations, printing and publishing separately.

As we need persons with good qualifications (M.Phil preferred as they would have experience in Research methodology) and some experience, it was suggested that the Research Assistant being employed for the short period of six months may be paid Rs.3,500/- - 4,000/- p.m. depending on qualifications and experience.

It may be necessary to meet the expenditures such as typing, stationery, etc., of the contributors so that the expenses do not become a burden on them.

It was suggested that by the end of August initial correspondance to get the consent of the resource persons should be over. This may also be done by personal contact.

The Meeting came to an end with vote of thanks by Mr.Alok Mukhopadhyay, Executive Director, VHAI, New Delhi.

STATE OF KARNATAKA'S HEALTH

Community Health Cell has been entrusted with the responsibility of preparing the chapter on "Medical and Nursing Education" and, is collaborating with other resource persons on the chapters on "Health Systems and Services in Karnataka" and "Child Health".

Since the last meeting, CHC is actively involved in the work of "State of Karnataka's Health Report". As a first step in this direction, an annotated bibliography of the relevant material available in the CHC library has begun. A list of more than a hundred resource persons/organisations has been made and letters seeking their active cooperation has been sent out.

We intend to adopt the format followed by VHAI's "State of India's Health", with appropriate modifications, taking our priorities into considerations. However, as to the chapter on 'Medical and Nursing Education', it was found that VHAI's approach and orientation is inadequate to our needs and a separate format will be followed.

CHC has already undertaken a project on Medical Education, and the separating of material relevant to Karnataka is proposed to be undertaken. Data etc., on Nursing Education is to be collected, and letters to the concerned individuals and organisations have already been sent.

The general outline of the chapter on "Health systems and services" is,an attempt will be made to present a balanced picture of both quantitative and qualitative data. For this, data collection

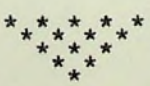
..2

is intended to be made with the help of NGOs and PG studies on health economics and health education in addition to the updating with available governmental and other data. Also, journals, magazines and newspapers will also be referred to.

Case studies of certain projects are intended to be taken up for critical analysis. Special emphasis will be placed on maternal care, child care, and allied sectors like water, sanitation and agriculture. The chapter also covers relevant data about State health plans, budget allocations, targets and achievements, and strategies adopted. A general survey of available private health services like the nursing homes, pathological laboratories, private consultants will also be included.

We like to devote the month of October for corresponding, contacting and the collection of material. By the end of November we should be able to compile all available data and wish to prepare the first draft with appropriate charts, diagrams etc., by December end, so that the draft can be circulated for discussion and to identify the lacuane.

Keeping the VHAI report in view, human interest and important issues like successful alternate NGO efforts, diseases peculiar to Karnataka, issues on tribal health, etc. We request the members to give access to information which you may have and facilitate our work.



HEALTH SYSTEMS AND SERVICES

01. Primary health care -- 3 evaluational studies.

02. Immunisation surveys -- Bangalore and Chikmagalur.

03. NGOs -- Mallur. Other reports are too general/ outdated. No focus on specific action taken. Distribution not known. Linkages to development -- very ambiguous.

04. Few Government of Karnataka publications - needs updation.

05. Specific Diseases covered -- Diarrohea; Handigodu; and Kyasanooru forest disease.

06. Miscellaneous -- lack of infrastructure. Bonded labour.

Child Health

01. Coverage of Immunisation programme.

02. ICDS - reports/evaluation - few.

Medical and Nursing Education

Nursing Education section needs material.

VOLUNTARY HEALTH ASSOCIATION OF KARNATAKA

Minutes of the Meeting of the contributors to the State of Karnataka's Health Report held on Friday October 15, 1993 at the Committee Room, Administrative Block, N I M H A N S, Bangalore - 560 029.

Meeting commenced at 3.00 p.m.

Members present

Dr.C.M.Francis
Ms.T.Neerajakshi
Dr.Jayashree Ramakrishna
Dr.P.H.Reddy
Dr.R.Srinivasa Murthy
Dr.Nataraj
Dr.(Mrs) Jayashree Nataraj
Dr.Kusuma
Mr.S.M.Subramanya Setty
Mr.Prabhu Dandavatimath
Dr.G.V.Nagaraj
Dr.Shoba Raghuram
Ms.Ruma Bannerjee
Dr.M.S.Rajanna
Mrs. Gangamma

Ms.T.Neerajakshi on behalf of VHAK & VHAI welcomed the Members and said that though many of the contributors have consented but could not attend this meeting, have sent their apologies.

After self introduction Dr.C.M.Francis gave a brief historical background of the initiative to bringout the State of Karnataka's Health Report and which would possibly help in bringing out the Health Policy of Karnataka. The minutes of the previous meeting held on September 18 were read out briefly particularly the portion dealing with chapters and the contributors for the same. Comments and suggestions from the members were invited. The following emerged out of the interaction.

1. Socio Economic Factors affecting Health.

This would give an over view of the Socio-Economic situation to place Health issues in the proper perspective. It would include population, employment, education, income and purchasing power, food, housing, water and sanitation and disparities between different regions.

Dr.P.H.Reddy, Director, Population Centre offered to contribute to this chapter along with his collegue Dr.Y.S.Gopal.

2. Food.

This chapter would include Food Production, Availability, Consumption, Adulteration, Contamination use of pesticides and also nutrition including Mal-Nutrition, Nutrition supplements and Micro nutrients Prof.Somashekar Reddy, Dr.Achaiah, Dr.Bhavani Belvadi will contribute to this chapter. The name of Dr.Jalaja Sundaram was suggested and regarding food adulteration the Public Health Institute may be contacted.

3. (a) Environment & Health.

The following persons will be the contributors

Mr.A.N.Yellappa Reddy

Dr.S.R.Hiremath
Mr.Prabhu Dandavatimath
} Samaja Parivarthana Samudaya Dharwad.

Mr.Panduranga Hegde

(b) Occupational Health.

There was no response from Dr.Nag this may be followed up Dr.Rajmohan also of the Regional Centre may be contacted. There was a suggestion that Members of the Association of Occupational Health may be contacted.

4. Health systems & Services.

Dr.S.P.Tekur, Dr.G.V.Nagaraj and Prof.Shanmugam will be the contributors. It was suggested Dr.M.K.Sudarshan HOD of Community Medicine, KIMS may also be contacted.

This chapter will also deal with STD & AIDS.

5. Indegineous systems of Medicine.

After brief discussion the following persons were identified for different systems besides Dr.Upendra Shenoy, Dr.Nataraj Dr.(Mrs) Jayashree Nataraj, Dr.Lucas for Ayurvedic Medicine.

Dr.S.P.Tekur - Accupressure & Accupuncture
Dr.Nagarathnamma - Yoga Therapy

Dr.A.Ramdas
Dr.G.Prakash
} - Homeopathy

Prof. S.A.Huk	- Unani
Dr.M.Kumar	- Sidda
Mr.Dham	- Mangneto Therapy
Dr.H.Sudarshan Mrs.Gangamma	- Tribal Medicine

suitable person may be identified for Naturopathy.

6. Population & Family Welfare.

Dr.P.H.Reddy will contribute this chapter with the colloboration of Dr.Sudha Xirasagar if she is willing to do so.

7. Child Health.

Dr.Saraswathy Ganapathy
Dr.C.Prasanna Kumar
Dr.S.P.Tekur
Dr.Hanumantharayappa

It was suggested Dr.Benakappa and Prof.Nirmala Kesaree of Davanagere may also be contacted.

8. Health Education and Health Awareness.

a. Health Man power development
b. Health communication
c. Health awareness

The following persons will be contributing

Dr.Jayashree Ramakrishna
Mr.S.M.Subramanya Setty
Dr.Uma
Dr.Rajanna
Dr.Saraswathy Ganapathy

It was suggested the relevant Resource Materials available at the Regional Health & Family Welfare Office may be tapped.

9. Medical and Nursing Education

Dr.Shirdi Prasad Tekur (CHC)

10. Health Information systems.

Dr.Bhatia

11. Women & Health

Dr.M.K.Vasundhara
Dr.Saraswathy Ganapathy
Dr.Bhatia
Ms.Janaki Rao
Mrs.Philomena
Dr.K.S.Raghavan

This chapter will also incorporate Reproductive Health & Adolscent Girl.

12. Health & Research

Dr.M.K.Vasundhara
Dr.C.R.Chandrashekar

13. Health Financing

Dr.Shoba Raghuram

14. Legal Issues

Mr.M.K.Ramesh

15. Disabilities

Dr.S.Pruthvish
Ms.Indumathi Rao

16. Mental Health

Dr.R.Srinivasa Murthy

17. Panchayat Raj and its impact on Health (Decentralised Health Care)

Prof. B.K.Chandrashekar
Dr.Makapur

It was proposed that Sri.T.R.Satish Chandran, Ex Director, ISEC may also be requested to contribute for this chapter.

18. Role of Voluntary Organisation in Health Care in Karnataka.

Dr.H.Sudarshan
Ms.T.Neerajakshi
C H C

Dr.C.M.Francis recalling the suggestion of a one day's programme with presentation of each topic, informed that the same has been fixed for Friday November 19, 1993 at which a

contributor of each chapter will present the outline of the proposed chapter. The programme will commence at 10.00 a.m. Each presentation will be of about 7 minutes duration to be followed by discussion by the group. The meeting is expected to be over by 4.00 p.m. lunch will be provided. The discussion is meant to bringout the adequacy of coverage of the topics and also to ensure that there would be no overlapping or duplication.

Group Meetings: It was felt necessary that the contributors of a particular chapter which would be authored by more than one person to meet before the workshop and finalise the outline. VHAK was requested to co-ordinate the group meetings.

Schedule: The following schedule to the drafts to VHAK was suggested and accepted:

Ist draft to be ready and sent to VHAK - 1.1.1994
2nd draft to be ready and sent to VHAK - 1.2.1994
Final draft to be ready and sent to VHAK- 21.2.1994

All manuscripts in their final form must be received by this date for editing so as to maintain uniformity of language etc., The Edited manuscripts will be sent to VHAI, New Delhi on or before 31.3.1994 for printing and publishing.

The contributors are requested to write to VHAK for required Resource Materials specifying from where the same could be procured. VHAK would also help in conducting pilot studies if necessary.

The outline of the chapter to be presented on 19.11.1993 may be sent to VHAK in advance to be distributed.

If any relevant Resource Materials (data, writeups, paper cuttings etc.) available with the contributor other than their subjects may be sent to VHAK to be shared with others.

The contributors of chapter Health Systems and Services would be meeting on Saturday Oct.23, 1993 at 3.00 p.m. in the Office of Dr.G.V.Nagaraj, Jt.Director, Health & F.W.Services, Directorate of Health Services, Anandarao Circle, Bangalore 560 009.

Vote of thanks was proposed by Ms.T.Neerajakshi.

The next Meeting (workshop) is scheduled for Friday 19.11.1993 at Seminar Hall, Library Block 1st Floor, NIMHANS, Bangalore at 10.00 a.m.

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ಆಯುರ್ವೇದ ಔಷಧ ಬೆಳೆಗಳ ಅಭಿವೃದ್ಧಿಗೆ ಕರೆ

ಬೆಂಗಳೂರು, ಅ. 29 - 'ಹೊಸ ರೀತಿಯ ಮಾರಕ ರೋಗಗಳು ತಂದೊಡ್ಡುವ ದುಷ್ಪರಿಣಾಮಗಳನ್ನು ತಡೆಗಟ್ಟಬಹುದಾದ ಆಯುರ್ವೇದ ಔಷಧಿಗುಣವಿರುವ ಬೆಳೆಗಳ ಬಗ್ಗೆ ಹೆಚ್ಚಿನ ಪ್ರಚಾರ ಆಗಬೇಕು' ಎಂದು ಕರ್ನಾಟಕ ರಾಜ್ಯ ಆಯುರ್ವೇದ ಮತ್ತು ಯುನಾನಿ ಪ್ರಾಕ್ಟೀಷನರ್ ಮಂಡಲಿಯ ಅಧ್ಯಕ್ಷ ಡಾ. ಜಂಬುಪ್ರಕಾಶ್ ನಾರಾಯಣ್ ಅವರು ಅಭಿಪ್ರಾಯಪಟ್ಟರು.

ಚಿಕ್ಕಬಳ್ಳಾಪುರ ರೈತರ ಅಭಿವೃದ್ಧಿ ಸಂಘದವರು ನಗರದಲ್ಲಿ ಗುರುವಾರ ಏರ್ಪಡಿಸಿದ್ದ 'ಸುಗಂಧ ದ್ರವ್ಯ ಮತ್ತು ಔಷಧಿ ಸಸ್ಯಗಳ ಅಭಿವೃದ್ಧಿ ಹಾಗೂ ಸಂಸ್ಕರಣ' ಕುರಿತ ಮೂರು ದಿನಗಳ ಕಾರ್ಯಾಗಾರ ಮತ್ತು ಪ್ರಾತ್ಯಕ್ಷಿತೆ ಕಾರ್ಯಕ್ರಮದ ಅಧ್ಯಕ್ಷತೆ ವಹಿಸಿದ್ದ ಅವರು, 'ಇಂತಹ ಬೆಳೆಗಳ ಅಭಿವೃದ್ಧಿಯತ್ತ ಹೆಚ್ಚಿನ ಗಮನಹರಿಸಬೇಕು' ಎಂದು ಕರೆ ನೀಡಿದರು.

ಕಾರ್ಯಾಗಾರವನ್ನು ಉದ್ಘಾಟಿಸಿದ ಐಡಬ್ಲ್ಯೂಎಸ್‌ಟಿ ನಿರ್ದೇಶಕ ಡಾ. ಪಿ.ವಿ. ಶ್ರೀನಿವಾಸ್ ಅವರು 'ವೈಜ್ಞಾನಿಕ ಕ್ರಮಗಳನ್ನು ಅನುಸರಿಸಿ ಬೆಳೆಗಳನ್ನು ಬೆಳೆಯುವುದಕ್ಕೆ ಗಮನಹರಿಸಿ ಆರ್ಥಿಕವಾಗಿ ಮುಂದುವರೆಯಬೇಕು' ಎಂದು ಬೆಳೆಗಾರರಿಗೆ ಮನವಿ ಮಾಡಿದರು.

'ಔಷಧ ಗುಣವಿಲ್ಲದ ಸಸ್ಯಗಳೇ ಇಲ್ಲ. ಮಾರಕ ರೋಗಗಳ ನಿವಾರಣಾ ಶಕ್ತಿಯನ್ನು ಹೊಂದಿರುವ ಸಸ್ಯಗಳ ಬಗ್ಗೆ ಅಧ್ಯಯನ ಮುಂದುವರೆದಿದೆ' ಎಂದು ಹೇಳಿದ ತೋಟಗಾರಿಕೆ ಇಲಾಖೆಯ ಜಂಟಿ ನಿರ್ದೇಶಕ ಡಾ. ಎಸ್.ವಿ. ಹಿತ್ತಲಮನಿ ಅವರು, 'ಸೂಕ್ಷ್ಮ ಸಂಸ್ಕರಣಾ ಘಟಕಗಳನ್ನು ಅಳವಡಿಸುವುದರಿಂದ ಸುಗಂಧ ದ್ರವ್ಯ ಸಸ್ಯಗಳ ಬೆಳೆಗಾರರು ಆರ್ಥಿಕವಾಗಿ ಮುಂದೆ ಬರಲು ಸಾಧ್ಯವಾಗುತ್ತದೆ' ಎಂದರು.

ಕಾರ್ಯಾಗಾರದಲ್ಲಿ ರಾಜ್ಯದ ವಿವಿಧ ಭಾಗದಿಂದ ಆಗಮಿಸಿದ್ದ 46 ಫಲಾನುಭವಿಗಳು ಭಾಗವಹಿಸಿದ್ದರು. ಆರಂಭದಲ್ಲಿ ಸಂಘದ ಪ್ರಧಾನ ಕಾರ್ಯದರ್ಶಿ ಎಂ. ರಾಜಯ್ಯ ಅವರು ಸ್ವಾಗತಿಸಿದರು.

ಶಾಲಾ ಸುಧಾರಣಾ ಸಮಿತಿಗೆ ನೇಮಕ

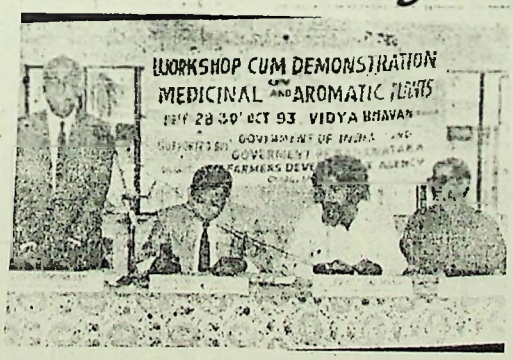
ಚಿಕ್ಕಬಳ್ಳಾಪುರ, ಅ. 29- - ಇಲ್ಲಿನ ಸರ್ಕಾರಿ ಪ್ರಥಮ ದರ್ಜೆ ಕಾಲೇಜಿನ ಸುಧಾರಣಾ ಸಮಿತಿಯನ್ನು ನೂತನವಾಗಿ ರಚಿಸಲಾಗಿದೆ.

ಈ ಸಮಿತಿಯ ಪದಾಧಿಕಾರಿಗಳಾಗಿ ಶಾಸಕ ರೇಣುಕಾ ರಾಜೇಂದ್ರನ್ (ಅಧ್ಯಕ್ಷ), [illegible] ಆಯ್ಕೆಯಾಗಿದ್ದಾರೆ.

ಹವಾಮಾನ

ಒಣ ಹವೆ ಮುಂದುವರಿಕೆ
ದೀಪ ಬೆಳಗಿಸುವುದರ ಮೂಲಕ ಪಿಬ

ಸುಗಂಧ, ಔಷಧಸಸ್ಯಗಳ ಕೃಷಿಗಾಗಿ ಕರೆ



ಚಿಕ್ಕಬಳ್ಳಾಪುರ ಅ.೨೯

ರೈತರು ವೈಜ್ಞಾನಿಕ ಕ್ರಮಗಳನ್ನು ಅನುಸರಿಸಿ ಔಷಧಿ ಮತ್ತು ಸುಗಂಧ ದ್ರವ್ಯ ಸಸ್ಯಗಳನ್ನು ಬೆಳೆಯುವುದರಿಂದ ಆರ್ಥಿಕವಾಗಿ ಮುಂದುವರೆಯಲು ಸಾಧ್ಯ. ಆದರೆ ನಕಲಿ ಬಿತ್ತನೆ ಬೀಜಗಳ ಬಗ್ಗೆ ಅವರು ಸದಾ ಜಾಗರೂಕರಾಗಿರಬೇಕೆಂದು ಸಸ್ಯ ವಿಜ್ಞಾನ ತಂತ್ರಜ್ಞಾನ ನಿರ್ದೇಶಕ ವಿ. ವಿ. ಶ್ರೀನಿವಾಸನ್ ಅವರು ನುಡಿದರು.

ಅವರು ಪಟ್ಟಣದ ರೈತರ ಅಭಿವೃದ್ಧಿ ಸಂಸ್ಥೆಯ ವತಿಯಿಂದ ಬೆಂಗಳೂರಿನ ವಿದ್ಯಾಭವನದಲ್ಲಿ ಏರ್ಪಡಿಸಿರುವ ಸುಗಂಧ, ಔಷಧಿ ಸಸ್ಯಗಳ ಕಾರ್ಯಾಗಾರವನ್ನು ಉದ್ಘಾಟಿಸಿ ಮಾತನಾಡಿದರು.

ಮುಖ್ಯ ಅತಿಥಿಯಾಗಿದ್ದ ತೋಟಗಾರಿಕೆ ಇಲಾಖೆಯ ಜಂಟಿ ನಿರ್ದೇಶಕ (ಅಭಿವೃದ್ಧಿ) ಎಸ್. ವಿ. ಹಿತ್ತಲಮನಿಯವರು ಸಾವಿರಾರು ವರ್ಷಗಳಿಂದ ರೋಗ ನಿವಾರಣಾ ಶಕ್ತಿ ಹೊಂದಿರುವ ಸುಮಾರು ಐದು ಸಾವಿರ ಸಸ್ಯಗಳಿವೆ. ಅವುಗಳ ಬಗ್ಗೆ ಅಧ್ಯಯನ ಮುಂದುವರೆದಿದೆ. ವಿದೇಶಿ ಮಾರುಕಟ್ಟೆಯಲ್ಲಿ ಅಪಾರ ಬೇಡಿಕೆ ಹೊಂದಿರುವ ಈ ರೀತಿಯ ಸಸ್ಯಗಳ ವ್ಯವಸಾಯಕ್ಕೆ ಕೃಷಿಕರು ಮುಂದೆ ಬರಬೇಕೆಂದು ಕರೆಯಿತ್ತರು.

ರಾಜ್ಯ ಆಯುರ್ವೇದ, ಯುನಾನಿ ವೈದ್ಯರ ಮಂಡಲಿ ಅಧ್ಯಕ್ಷ ಜಯ ಪ್ರಕಾಶ್ ನಾರಾಯಣ್‌ರವರು ಅಧ್ಯಕ್ಷತೆ ವಹಿಸಿದ್ದು ವಿಜ್ಞಾನ ಮುಂದುವರೆದಂತೆಯೂ ಬಗೆಯ ಮಾರಕ ರೋಗಗಳು ಹುಟ್ಟುತ್ತಿರುವುದು ವಿಪರ್ಯಾಸ. ಆಯುರ್ವೇದೀಯ ಔಷಧಿಗಳು ಇಂತಹ ಬೇನೆಗಳಿಗೆ ಸೂಕ್ತ ಮದ್ದಾಗಿವೆಯೆಂದರು.

ರಾಜ್ಯದ ವಿವಿಧ ಭಾಗಗಳಿಂದ ಈ ಕಾರ್ಯಾಗಾರದಲ್ಲಿ ೪೬ ಮಂದಿ ಪಾಲ್ಗೊಂಡಿದ್ದು, ಸಮನ್ವಯಾಧಿಕಾರಿ ಡಿ. ರಾಮಚಂದ್ರರಾವ್ ಮಾತನಾಡಿದರು.

ಎಂ. ಸರಸ್ವತಿರಿಂದ ಪ್ರಾರ್ಥನೆ, ಎಫ್‌ಡಿಎ ಪ್ರಧಾನ ಕಾರ್ಯದರ್ಶಿ ಎಂ. ರಾಜಯ್ಯನವರಿಂದ ಸ್ವಾಗತ ಮತ್ತು ಕಾರ್ಯಕ್ರಮ ಅಧಿಕಾರಿ ಪಿ. ವಿ. ಮುನಿಸ್ವಾಮಿಯವರಿಂದ ಆಭಾರ ಮನ್ನಣೆ ಗಳಾದವು.

♥ವಿಶ್ವಶಾಂತಿ, ಭದ್ರತೆಗಾಗಿ ವಿಶ್ವ ಸಂಸ್ಥೆಯು ನಡೆಸುತ್ತಿರುವ ಪ್ರಯತ್ನಗಳನ್ನು ಬೆಂಬಲಿಸುವಂತೆ ಕಾಮನ್‌ವೆಲ್ತ್ ರಾಷ್ಟ್ರಗಳ ಸರ್ಕಾರಿ ಅಧಿಪತಿಗಳ ಸಭೆ ಕರೆಯುತ್ತಿದೆ.

ROUGH OUTLINE OF CONTENTS FOR SECTION ON CHILD HEALTH AND WELL-BEING

(Note that all this will need to be modified depending on the contents of other chapters, but I feel the areas mentioned must be covered at some stage in the report)

-Indicators of child health. IMR, immunization coverage etc. To include education, working children and other such 'social' indicators.

- Major programmes for children (and women, where relevant) in the state. Evaluation of implementation and functioning of the programmes. Critique of overlap in programme aims, single focus programmes where need is for holistic approach. Distribution of ICDS; schools, PHCs etc.

Perinatal period. Effect of the ante-natal period, evaluation of ante-natal care services. Delivery and neonatal period - practices, use of services, role of low birth weight/prematurity. Imbalance between provision of secondary and tertiary services and need for good primary services. Infant mortality - changes in, relevance of.

G.V. Nagaraj & Gopal

- Early childhood. Patterns of morbidity and deaths. Effect of socio-economic factors. Use of services, adequacy of response to illness. Gender differences.

- The adolescent period. Socio-cultural perceptions of the period. Menarche. Needs of the adolescent girlchild. Early marriage and child-bearing.

- The nutritional status of children. Prevalence of malnutrition, specific nutritional deficiencies. Over-nutrition in well to do households. Breast feeding and weaning - observations, traditional practices, commercialization. Intra-family distribution of food.

- Psychological needs and observed practices.

(All the above areas should be discussed in the context of gender differentiation,(female foeticide?), caste differences, urban/rural differences, effect of education)

-Education. Need for pre-school and primary, content should be relevant.

- Importance of traditional practices - evaluate effect, positive/negative.

-Working children, destitute and street children. Need for services, evaluation of existing services, adoption. → Nimita Chandy etc.

-Disability. Separate section? CWC.

Immunizn. Critical studies - St. John's

S. Ganapathy

ISEC → Primary Education.

→ Accidents in Children. (15 pages)

Genetics = Sex determination.

Socio-Economic Factors Affecting Health

P.H. Reddy and Y.S. Gopal

At the outset, the concept of "health" will be clarified. Expectation of life at birth, crude death rate and infant mortality rate will be regarded as indicators of health status of people. Morbidity can also be taken as an indicator for health status of people depending upon the availability of data.

Health status of people depends not only on the availability of health facilities and services, but also on a number of socio-economic factors. It has been said that dispensaries, doctors and drugs account for only 10 per cent of the health status of people and 90 per cent is accounted for by socio-economic factors.

Therefore, this chapter will make an attempt to analyse the association of health status of people with such socio-economic factors as region, religion, literacy, per capita income, percentage of workers engaged in non-agricultural activities, female work participation, degree of urbanisation, sex ratio, household size, population density, dependency ratio, number of hospital beds per 100,000 population, number of ANMs, LHVs and doctors per 100,000 population, percentage of deliveries conducted by trained personnel and eligible

couples effectively protected by different family planning methods.// Thus, this chapter will make a general overview of the health status of people in Karnataka. Wherever necessary and possible, district as the geographical unit of analysis will be taken. This is in addition to taking the state of Karnataka as a whole as the unit of analysis.

Population and Family Welfare

P.H. Reddy and Y.S. Gopal

This chapter will be divided into two parts. Part I will deal with population growth in Karnataka since the first Census taken in 1872. It will also deal with age-sex composition of the population, sex ratio, population density, etc. Trends in birth rate, death rate, infant mortality rate, in-migration and out-migration will also be analysed. An attempt will also be made whether these factors vary by district.

Part II will deal with the history of family welfare in Karnataka, progress of family welfare programme since its inception in 1951, couples effectively protected by different family planning methods, average age of tubectomy acceptors and wives of vasectomy acceptors, average number of living children of sterilisation acceptors, average age of IUD acceptors and changes, if any, in these characteristics over a period of time. An attempt will also be made to assess the impact of the family welfare programme on the birth rate and the number of births averted by the programme.

VOLUNTARY HEALTH ASSOCIATION OF KARNATAKA

Minutes of the Meeting of the contributors for State of Karnataka's Health - Report held on Friday November 19, 1993 at the Seminar Hall NIMHANS, Bangalore.

Member present:

Dr.Upendra Shenoy
Dr.C.M.Francis
Ms.T.Neerajakshi
Mr.R.K.Dham
Dr.Prabhu Dandavatimath
Mr.Shivannagowda Doddamani
Mr.Basavaraj Magdum
Dr.Syed Shahabulhaq
Dr.D.S.Lucas
Dr.Rangesh Paramesh R
Dr.Shirdi Prasad Tekur
Mr.Soumya Kumar
Dr.C.R.Chandrashekar
Dr.Y.S.Gopal
Dr.Saraswathy Ganapathy
Dr.B.N.Prakash
Mr.S.M.Subramanya Setty
Ms.Sucharita S.Eashwar
Dr.B.S.Nataraj
Dr.H.Sudarshan
Mr.Ramappa

This meeting was specifically convened for the contributors to present the outline of the chapters and for the discussion there on.

After the self introduction of the members Dr.Upendra Shenoy,Hon. Secretary welcoming the members present briefed about the context of bringing out the Report as some of the members were new.

Dr.Saraswathy stated that it was not possible to work within the time frame specified. She also enquired whether the contributors will be renumerated for their time, energy and expertise. Dr.S.P.Tekur said that it has been difficult to meet in group where there are more than one contributor. He wanted VHAK to co-ordinate the Group Meetings.

There was a suggestion that State of India's Health be made available for all possible contributors, Ms.Neerajakshi said that since it is a priced publication the report would be just given for reference only to the contributors who really need it.

After discussions the schedule was modified as follows:

First draft to be sent to VHAK before 1.3.1994. Final draft to be sent to VHAK incorporating modifications necessary on or before 31.3.1994. It was agreed that VHAK will co-ordinate the group meetings.

The proposed chapters were then taken up for presentation of outline and discussions. The following outline for each chapter emerged after the presentation by the respective members present and the discussion that was followed:

1. SOCIO - ECONOMIC FACTORS AFFECTING HEALTH (10 - 15 printed pages)

Dr. P.H.Reddy
Dr.Y.S.Gopal

Population (brief); House

Employment; agricultural & non-agricultura; female workers, non-employment; under employment.

Education: literacy; female literacy

Income: per capita; poverty

Purchasing power

Food (brief)

Housing, water and sanitation

Disaprities between different regions (district as the geographical unit)

Religion; ethnic groups

Urbanisation

2. FOOD AND NUTRITION (30 - 35 printed pages)

Prof.Somashekar Reddy, Dr.Achaiah, Dr.Bhavani Belvadi and Dr.Jalaja Sundaram

2.a) FOOD

Food production: Cereals, Pulses, Oil
Milk, eggs, meat, fish

Food needs/demand

Food security

Availability, utilization, consumption

Purchasing power

Food contamination; adulteration
pesticides; chemicals

Food processing

Food storage, wastage

Public distribution system

Drought; poverty alleviation

Boxes on junk foods ; CFTRI

2.b) NUTRITION

Nutritional requirements; energy requirements

Nutritional situation in Karnataka - different districts, regions

Malnutrition and poverty/socio cultural factors/availability of food, Malnutrition - prevalence ; grades

Micro nutrients

Women and nutritional status

Mal nutrition and vulnerable groups : 0-1 year; 1-5 years; adolescence; youth; girl child; pregnant; elderly; landless labourers; slum dwellers.

Approaches and programmes to combat malnutrition

Five year plans Agriculture/ and health

ICDS

Special and supplementary nutrition programmes

Applied nutrition programmes

Nutritional anaemia - National programme (implementation in Karnataka)

National Blindness control programme (Vit.A deficiency) -Karnataka

Nutrition education; training in nutrition

Tribal nutrition

Marketing (infant; baby foods) : negative impacts

Policy implication, strategies

Recommendations : Long term ; short term

Tables : Calories, ~~xxx~~ Proteins, Vit A, Iron

3.a) ~~ENVIRONMENTN~~ ENVIRONMENT AND HEALTH (15 printed pages)

Mr.A.N.Yellappa Reddy, Dr.S.R.Hiremath & Dr.Prabhu Dandavathimath

Environmental (resource etc) degradation; ecological changes

Deforestation/afforestation

Excessive use of ground water ; fuel

Subsistance cropping; cash cropping

Industries and their impact

pollution (all kinds); action by government; action by Voluntary Organisations

Sustainable development: rural;urban;tribal

Disasters: floods, droughts, etc

Box (High tension wires and health problems)

Quarrying and mixing

Marine (travellers) ; birds; national sanctuary

Critical analysis

3.b) OCCUPATIONAL HEALTH

(Outline to be worked out)

4. HEALTH SYSTEMS AND SERVICES (40 - 45 printed pages)

Dr.S.P.Tekur, Dr.G.V.Nagaraj, Prof.Shanmugam & Dr.M.K.Sudarshan

(1) Historical : Evolution of health care services in different regions of Karnataka

(2) Health care facilities

Government, private, Voluntary, corporate, industry, co-operative

Hospitals; beds.

Subcentres, PHCs, CHCs, Taluk, District, Teaching, Speciality Health units, Nursing homes, laboratories

Rural; urban slums - health care services + TRIBAL

General practitioners

Doctors - general ; specialists
Nurses - general ; specialisation
Dentists - general ; specialisation
Pharamacists - general ; specialisation

} Working in various places

Technicians (Laboratory, X-ray, etc)

Physiotherapists/Occupational Therapists/others

Blood banks (blood transfusion services)

Burns units

Indicators and targets

Crude birth rate; crude death rate

IMR; < 5 death rate; maternal mortality rate; perinatal; neonatal mortality / Changing trend in morbidity

Life expectancy at birth

Death rates specific to age, sex, cause

National control/eradcation programmes (Malaria; Filaria; Tuberculosis; Leprosy, STD, AIDS; Blindness; Diarrhoeal diseases; Guinea - worm, Goitre)

Immunization

Infectious diseases, Food poisoning Enteric Fever / Resp. diseases / Hansdigod / K.F.D.

Cardiac, pulmonary, kidney disorders; anaemias; cancer

Five year plans; budget; expenditure on health

Mobile health units

Accidents

Drug controller; Drug production, utilization; qualitye control; supply; rational use of durgs, hospital pharmacies.

Drug stores

Public health laboratories

People's perception of health services; under services; under utilization of Government services.

Agriculture & Health / Panchayati Raj & Health.

Boxes on
NIMHANS, KIDWAI, JAYADEVA, NTI, BELGAUM INSTITUTE
STD/HIV; AIDS

5. INDIGENOUS SYSTEMS OF MEDICINE (25 - 30 pages)

Dr.S.P.Tekur - Accupressure & Accupuncture
Dr.Nagarathnamma - Yoga Therapy
Dr.S.N.Prakash - Homeopathy
Prof.S.A.Huk - Unani
Mr. Dham - Magneto Therapy
Dr.Upendra Shenoy
Dr.Nataraj
Dr.Jayashree Nataraj
Dr.Lucas
} Ayurveda

Dr.H.Sudarshan
Mrs.Gangamma
} Tribal medicine

- Naturopathy

Ayurveda
Unani
Homeopathy
Naturopathy
Yoga
Magneto Therapy
Accupuncture
Accupressure
} to be dealt in detail

Traditional medicines: Herbal, Home, Folk
Tribal
Tibetan
} in brief

Historical background; present state
Hospitals | Government
Nursing homes | Voluntary
Dispensaries | Private
Units | Beds
Education in the various systems
Research & Facilities
} to be worked out and then transferred to other appropriate chapters

Practitioner : general; specialists
Pharmacies
Nurses

Journals, magazines, newspapers coverage, radio doordarshan

Cultivation of medicinal plants; patenting

Production of medicines; drug control; standardisation

Drug utilisation

People's perceptions and attitudes; utilisation of services

Future: recommendations.

6. POPULATION & FAMILY WELFARE (15 printed pages)

Dr.P.M.Reddy & Dr.Y.S.Gopal

6.1) Demographics - Karnataka

Population; growth since 1872; projections for Karnataka; trends cities - Bangalore; Hubli-Dharwad; Mangalore - Districts.

Age; Sex; Sex - ratio

Population density

Composition of population

Migration to and from Karnataka

6.2) Family Welfare

M C H Programmes

Family Planning

Methods

Couple protection

Acceptors

Effectiveness; Number of births averted

Impact on birth rate, etc

Natural Family planning

Folk practices

Critical analysis; reliability of data

Family planning from Women's perspective

7. CHILD HEALTH (15 printed pages)

Dr.Saraswathy Ganapathy

Dr.C.Prasanna Kumar

Dr.S.P.Tekur

Dr.Hanumantharayappa

Birth rate; Infant mortality rate; under 5 mortality rate

Life expectancy at birth

Perinatal care; delivery, neonatal care

Development - intrauterine growth retardation, low birth weight pre maturity

Artificial reproduction

Sex discrimination; amnioceutesis Gender diferencies in response to needs

Breast feeding; weaning
Nutritional status
Malnutrition, Micronutrients
Infectious diseases of childhood
Immunization - evaluation
Diseases of childhood, Mortality; morbidity
Psychosocial problems
Accidents
Street children
Child workers - especially hazardous occupations
School health
Adolesence
I C D S
Traditional practices
Major programmes for child health services; critique
Recommendations

8. HEALTH EDUCATION, COMMUNICATION, AWARENESS (20 - 25 pages)

Dr.Jayashree Ramakrishna, Mr.S.M.Subramanya Setty, Dr.Uma Dr.Rajanna

Health education for health action
Role of behaviour; effecting changes in habits
Communication; health messages
Media - print; newspapers, magazines, in kannada
Mass media: Radio; TV
Folk
Exhibitions
Hospital/clinic based health education/ patient education
School health education
Community involvement in health education
~~Child-to~~ Child-to-child education
Health education for various groups - farmers, others
Advertisements
Health awareness
People's beliefs and perceptions
Care during pregnancy, delivery, postnatal
Nutritional education
Specific problems - gynaecological etc
Taboo and practices
Health awareness among people's representatives; decision makers
Recommendations

9. HUMAN RESOURCES DEVELOPMENT IN HEALTH (40 - 45 printed pages)

Dr.Shirdi Prasad Tekur

Medical education

Government/private

Numbers; Numbers needed

Under graduate/post graduate; input/output; migration

Capitation fee

Supreme Court decisions

Case studies

Social relevance

Nursing education

Government/private

Numbers; Numbers needed

B.Sc/Certificate course/ANMs

Migration; attention

Capitation fee

Dental education

Government/private

BDS/MDS; input/output

Capitation fees

Pharmacy

Government/private

Degree/diploma

Numbers; numbers required

Health Assistants, Multipurpose worker, Health visitor

Technicians

X-ray, Laboratory, dental, ECG, others

Food inspectors

Physiotherapists/occupational therapists

Nutritionists/dieticians

Traditional birth attendants - trained

Community health workers/guides/volunteers

10. HEALTH INFORMATION SYSTEM (10 pages)

(Dr.Bhatia to give details)

Data; sources, collection, utilization; reliability, medical audit

11. WOMEN AND HEALTH (20 - 25 pages)

Dr.M.K.Vasundhara, Dr.Saraswathy Ganapathy, Dr.Bhatia, Ms.Janakirao Mrs.Philomena, Dr.K.S.Raghavan, Ms.Neerajakshi

Special problems of women's health
Under nutrition; anaemia
Mortality, morbidity
Maternal mortality, delivery
Victims of violence
Sex ratio, sex determination and discrimination
Girl child - neglect; exploitation; age of marriage; pregnancy
Women in health care services; problems; opportunities

12. RESEARCH (10 pages)
Dr.M.K.Vasundhara & Dr.C.R.Chandrashekar
Research relevant to the health problems in Karnataka
Include research in all systems
Boxes on research institutions

13. HEALTH FINANCING (10 pages)
Dr.Shobha Raguram
Government/private/Voluntary/ESI Corporation/Corporate sector/ Local bodies
House hold expenditure
Health outlays and expenditures; adsolute amounts and as percentage of total plan/budget
Breakdown by programmes
Health insurance; state/voluntary/private
Health cess

14. LEGAL AND ETHICAL ISSUES (10 printed pages)
Mr.M.K.Ramesh
Acts: Drugs and cosmetics Act, 1940 - Rational use of Drugs; Banned drugs; Public interest litigation; case studies.
Drugs and magic remedies Act, 1954
Prevention of Food Adulteration Act, 1955
Other Acts and Legislation

Advertising: alcohol; tobacco
Pollution; laws regarding; implementation
Medical negligence; Consumer protection Act, Case studies
Informed consent

Policies, law; Need for change; need for better administration of legislation; enforcement
Role of voluntary agencies
Critiquing

15. DISABILITIES (10 - 15 printed pages)

Dr.S.Pruthvish, Mrs.Indumathi Rao

Types; numbers

Institutions - Service, training, research

Rehabilitation

Accidents/injuries - occupational; agricultural, Household
Road/traffic; case studies

Aids and appliances

Community - based rehabilitations

16. MENTAL HEALTH (10 printed pages)

(Dr.R.Srinivasamurthy to give details)

Mentally ill; Prevalence; pattern

Mental health manpower; facilities; institutions
Out patient, ambulatory, inpatient care

Innovations - Family in care

Integration with general health care

School mental health

Boxes: Prevalence
Mental health

Mentally retarded: education/training; care

Voluntary agencies in mental health care in Karnataka

Psychosocial stresses

Boxes (Prevalence; Institutions/hospitals, innovations)

Addictions

Promotion of mental health; prevention of mental disorders

National programme and Karnataka

Future directions

17. PANCHAYATI RAJ AND IMPACT ON HEALTH (5 printed pages)

(Prof. S.K.Chandrashekar and Dr.Makapur to give details)

18. ROLE OF VOLUNTARY ORGANISATIONS IN HEALTH CARE IN KARNATAKA
(10 printed pages)

Ms.Neerajakshi & Dr.H.Sudarshan

a. Introduction

b. Definition

c. Brief back ground history

d. Evolution of voluntary movement in Karnataka

d. Various committees formed by the government

e. Voluntary work in health care as a People's movement number, type area of work of Voluntary organisations complete list with address including Rotary, Lions, Jaycees etc.,

f. Programme and Stratergies

Health & Health related Institutions - Integrated approach community development

g. Area - Need Assessment, planning, complimenting & supplimenting Government programmes, Liaison with government and other organisations, population and family welfare, monitoring, Health Education (awareness (consumer action) Information dissemination training programmes, Service camps, Campaigns). Evaluation

curative services, Research, Rehabilitation, Referral counselling, Intersectoral co-ordination, crisis management, Geriatic problems legislation.

h. Strengthens

i. Weakness - finance, personnel, skills, political interference non co-operation (State, District, Taluk & Panchayat)

j. Conclusion

O . KARNATAKA (10 printed pages)

Dr.C.M.Francis

History; geography - Maps, regions, districts

Karnataka at a glance

Educational facilities - centres of learning; universities

Museums, libraries, cultural centres; recreational centres; Sports complexes

Venicles; transport

Traffic accidents

Crime - murder rate - Kidnapping - abduction

Alcohol; tobacco

GUIDELINES

Actual state of affairs in Karnataka. Focus on Karnataka; comparison with All India and neighbouring states.

Historical; Minimal

What is new; innovative; special features

Future projections

Critique, Recommendations

Visuals - graphics, tables, pie diagrams, bar charts, pictures photographs, cartoons

Boxes

References (minimal) ; bibliography

Write-ups: A-4 size, typed, 1 1/2 spacing

The total number of pages has come to 305 (minimum) to 345 (maximum) printed pages with about 15 pages required for introduction, editorial, etc., the total would come up to 320-360 pages. There is little scope for increase (estimate: 300-350 printed pages) There can be some re-adjustments.

Boxes

① History of Karnataka's Health Services.
② Handigodu Syndrome
③ Kyasanur Forest Disease
④ NTI and other institutions/organisations

Dr. Shridi Prasad.

Conference
2/8/94

Total number of doctors in Kerala State : 4163 ?
Population served per doctor (Kerala) : 1:7213 ?

State of Karnataka's Health Systems & Services

NATIONAL HEALTH PROGRAMS:

1. National Leprosy Eradication Programme:

Karnataka is a state which has a moderate presence of leprosy as a health problem falling below 5 per 1000 population, though pockets of Karnataka have a higher incidence.

To estimate the population at risk, and compare with the surrounding states, the table below could help.

Source #5

	Prevalence rate per 1000 population	
	Estimated 1981	Recorded 1991
All India	5.7	2.50
Karnataka	5.98	1.88
A.P.	11.72	4.00
Kerala	2.95	2.15
Maharashtra	6.37	2.21
Tamil Nadu	15.14	3.56.

Source #5 Though Karnataka is better off than all its neighbours, except Kerala in identifying the disease expected, though not upto National levels.

Leprosy being a 'social' disease, a number of voluntary agencies have been part of the I.E.C. effort in N.L.E.P.

The progress under NLEP has been showing a good improvement in recent years.

Source #7

Year	New cases detected Target	Achievement	%	No. of cases discharged as disease arrested/cured Target	Achievement	%
1990-91	18,000	25,668	142.6	60,000	35,662	59.4
1991-92	22,000	25,796	117.2	46,000	43,443	94.4
1992-93 (upto Dec'92)	25,000	19,065	76.3	46,000	26,259	57.1

The physical components of the program in comparison with surrounding States is listed below Karnataka is comparatively better off.

Source #5

NLEP - Achievement of Physical components till March 1990

State	LCU/MLU	ULC	SET	THW	RSU	DLO	LTC	LRPU	SSAU
India	719	948	6097	291	75	244	45	13	39
Karnataka	41	52	673	22	6	20	5	2	3
A.P.	94	93	164	53	14	31	7	1	
Kerala	16	45	254	5	2	7	1	1	3
Maharashtra	42	281	970	23	11	24	7	2	1
T.N.	102	83	24	52	9	20	6	1	5

LCU - Leprosy Control Unit
ULC - Urban Leprosy Centre
THW - Temporary Hospital Ward
DLO - District Leprosy Officer
LRPU - Leprosy Rehabilitation Promotion Unit.
SSAU - Sample Survey cum Assessment Unit
MLU - Modified L.C.U.
SET - Survey & Educ. & Treatment Centre
RSU - Reconstructive Surgery Unit.
LTC - Leprosy Training Centre.

NATIONAL TUBERCULOSIS control PROGRAM

The National Tuberculosis control program is implemented through 22 Tuberculosis centres providing Institutional and Domiciliary treatment. There are 10 Government T.B. Hospitals with a total bed strength of 3,545 for treatment of complicated cases. - (1993-1994).

Source #7

Progress under N.T.C.P

Year	TB cases detected: Target	Achievement	%	B.C.G Vaccination: Target	Achmt	%
1990-91	85,000	77,437	91.1	186,000	162,948	87.6
1991-92	83,000	77,198	93.0	185,000	195,590	105.7
1992-93 (Upto Dec'92)	85,200	47,091	55.3	185,000	156,498	84.6

Karnataka has the National Tuberculosis Institute at Bangalore, whose initial surveys helped evolve the National program. (See box for N.T.I.).

A comparison of facilities for tackling tuberculosis among the southern states is given below:

(as on 31-12-1990)	No. of Distt	TB Dems. centres	Distt TB Centres	Total other TB clinics	No. of beds for TB
India	443	16	378	338	46,984
Karnataka	20	1	20	6	3545
A.P.	23	1	23	26	2,559
Kerala	14	1	10	9	2,283
Maharashtra	30	1	28	19	8,207
TN.	21	1	16	40	3,630.

Source #5

NATIONAL PROGRAM FOR CONTROL OF BLINDNESS:

Karnataka has the Regional Institute of Ophthalmology located at Bangalore. Eye camps are periodically conducted through eleven mobile ophthalmic units.

Progress under National programme for control of Blindness:

Source #7

Cataract Operations

Year	Target	Achievement	Percentage
1990-91	54,000	43,863	81.2%
1991-92	90,000	65,078	72.3%
1992-93 (Upto Dec 92)	90,000	52,740	58.6%

Vit 'A' prophylaxis is implemented under the ~~AWD~~/Nutrition/~~Immunisation~~ programme.

Source #7 ~~NATIONAL MALARIA~~

Prophylaxis against Vit 'A' deficiency.

Year	1st Dose Target	1st Dose Achievement	%	2nd Dose Target	2nd Dose Achievement	%
1990-91	2000,000	1909,054	95.5	2000,000	1815433	90.8
1991-92	3000,000	2023847	67.5	3000,000	2527346	84.2
1992-93 (Upto Dec'92)	2725,000	2264462	83.0	2725,000	—	—

NATIONAL MALARIA ERADICATION PROGRAM

This program is implemented on a 50:50 sharing basis between the Centre and State on certain components in all districts as per modified plan of operation guidelines. The integrated vector control program adds to the other remedial measures.

Source #7 Performance under NMEP :

Year	Blood smears Collected	Blood smears Examined	Total positive Cases	P.F Cases	Radical treatment given	ABER	S.P.R.	A.P.I.
1990	6601484	6601484	74012	23209	71905	17.5	1.1	1.9
1991	6646213	6646213	44565	10135	43430	17.2	0.6	1.1
1992 (provisional)	6864375	5376595	56600	11438	51533	13.9	1.0	1.4

P.F. — Plasmodium falciparum
ABER - Annual Blood Examination Rate
SPR - Slide Positivity Rate.
API - Annual Parasite Index.

An idea of trends between 1987 to 1990 in comparison to neighbouring states can be had from the table below:

Source #5

	1987 Cases / Deaths	1988 Cases/Deaths	1989 Cases/Deaths	1990 Cases/Deaths
India	1663284 / 188	1854830/209	2017823/268	1777248/222
Karnataka	88505/0	127008/8	106683/0	56980/0
A.P.	53010/1	62535/1	82510/2	81366/5
Maharashtra Kerala	3772/1	5147/1	6126/1	6411/1
Karnataka Maharashtra	60557/2	84030/5	122314/8	109806/6
T.N	55523/0	75953/0	90478/0	117428/0

NATIONAL GOITRE CONTROL PROGRAM

Preliminary surveys show the following districts as Goitre endemic areas – Uttara Kannada, Kodagu, Dakshina Kannada and Chickamagalur.

Progress achieved: Source #7

Year	No. of persons examined	No. of Goitre cases detected
1990 - 91	86,811	1,901
1991 - 92	25,656	6,034
1992 - 93 (Upto Dec'92)	16,895	5,237.

NATIONAL FILARIA CONTROL PROGRAMME:

Source #7 Filariasis is prevalent in the districts of Uttara Kannada, Dakshina Kannada, Gulbarga, Bidar Bijapur and Raichur Districts. Control measures are taken up through six Filaria control units and sixteen Filaria night clinics in all endemic areas.

GUINEA WORM ERADICATION PROGRAMME:

Source #7 The endemic districts are, Bijapur, Raichur and Gulbarga, where action is being taken for eradication.

Incidence of Guinea worm:

Year	Cases	Deaths.
1990	634	Nil
1991	226	Nil.
1992	167	Nil.

DIARRHOEAL AND COMMUNICABLE DISEASES CONTROL PROGRAMME

Incidence Source #7

Disease	1990 Cases / Deaths	1991 Cases / Deaths	1992 Cases / Deaths
1. Gastroenteritis	8565 / 391	17455 / 691	14088 / 561
2. Cholera	448 / 15	747 / 15	388 / 14
3. Viral Hepatitis	1807 / 30	659 / 17	270 / 9.
4. Japanese 'B' Encephalitis	138 / 47	305 / 114	46 / 11
5. Kyasanur Forest Disease	1309 / 31	967 / 16	1183 / 11
6. AIDS	58 / 1	86 / 1	59 / 1.

IMMUNIZATION UNDER I.C.D.S. Program

Source #7

Vaccine	Percentage achievement against Target 1990-91	1991-92	1992-93 (upto Dec '92)
1. B.C.G.	64.9	73.4	51.6
2. D.P.T.	57.4	70.5	45.7
3. Oral Polio	58.5	70.5	45.7
4. Measles	50.6	63.8	40.9
5. Tetatus (Mothers)	44.7	63.9	47.18.

"State of Karnataka's Health"

(1)

HANDIGODU SYNDROME :-

Ref: a) Handigodu Syndrome - A peculiar Orthopaedic problem
NIMHANS - Dr. K.S. Mani & Dr. H. K. Srinivasa Murthy
Directorate of Health and Family Planning Services, B'lore - 9.

b) ICMR Bulletin : Vol 7, No. 6, June 1977.

c) Report of the Investigation team of experts on Handigodu syndrome in Shimoga and Chikkamagalur Dt. - 1983.

d) Handigodu Syndrome - a mysterious disease
P.V. Aswath, M.K. Sudarshan
Karnataka Medical Journal, Vol. XLVIII, pp-103-107, Apr-Jun 1983.

e) Disease that seeks out SCs in Handigodu - N.C. Gundu Rao
Sunday Herald (Deccan Herald Sunday edition) 10 Apr 1988.

A "mystery disease" surfaced in the Malnad area of Karnataka in ~~the~~ January 1975, when four people from Handigodu village (of Sagar taluk, Shimoga district) reported to a local hospital complaining of inability to walk. This increased to thirty within a week, and all from the same village. Over three months, more cases were reported from Sagar taluk, the neighbouring Thirthahalli taluk, and even the adjoining district of Chikkamagalur.

This was called the Handigodu Syndrome where it originated, and excited the attention of the medical community, resulting in a number of studies by experts.

The major symptoms the patients had,

were pain in the hip, knee and shoulder joints, followed by stiffness and deformities ~~followed~~ in in these joints followed. No such cases were known ~~five~~ 6 to 8 years prior to these reports, ~~and~~ with a majority developing symptoms over a period of 4 to 6 years. There were no seasonal, or environment disaster related ~~&~~ reasons obvious, nor was it infective.

Some of the findings of studies by NIMHANS, ICMR and the Govt of Karnataka ~~known~~ could be ~~pointers~~ ~~affected are~~

- All age groups are affected from 4 to 60yrs with no gender predilection
- the poor and marginalised are primarily affected.
- ~~there seems to be~~ a strong familial tendency with three generations from ~~same~~ the same household.

A profile of those affected from the various studies done by NIMHANS, ICMR and the Govt. of Karnataka reveals the following - ~~that all age groups affected~~

- all age groups from 4 to 60yrs of age (with no gender differences) are affected.
- a strong familial tendency, with three generations from the same household being affected.
- the poor and marginalised ~~from~~ are the chief victims.
- the affected population has other forms of bone abnormalities like achondroplastic dwarfism, osteomalacia and rickets-like manifestations.
- with modernised farming methods being adopted, chemical fertilizers and pesticide usage is widespread, especially in the preceding decade.

- the consumption of fish and crabs from local fields and ponds had increased due to discontinuation of the practice of providing free food to agricultural labour, and,
- there has been a lot of in-breeding of the affected population due to social factors like caste and class.

It is also interesting to note that this same area of Malnad has been the focus of Kyasanur Forest Disease, though no connection has been established between KFD and Handigodu Syndrome.

This area of Malnad has not only been the focus for medical studies, but has also generated a number of rehabilitative measures from corrective orthopaedic surgery to socio-economic or physiotherapy oriented handloom weaving centres for the affected. The Government and Voluntary agencies are doing whatever they can, though it is not considered to be enough.

The question yet to be answered is:

- Is the syndrome - purely familial/genetic?
- due to chemical pesticides/fertilizers ingested with the crabs and fish?
- due to consumption of illicit liquor - as one study points out?
- due to faulty/inadequate diet?,

OR, IS IT JUST THE PHYSICAL MANIFESTATION OF MAN'S LACK OF CONCERN FOR A FELLOW UNDERPRIVILEGED HUMAN-BEING IN PURSUIT OF "PROGRESS" AND "DEVELOPMENT"?

VOLUNTARY HEALTH ASSOCIATION OF KARNATAKA

VHAK/C-22/EQ-1993

Office at: Rajini Nilaya, No.60
Ramakrishna Mutt Road
Cross, Ulsoor
Bangalore - 560 008

26TH NOVEMBER 1993.

Dear Sir/Madam,

We are confident, you all must have read through the papers, heard from Radio and seen in T V the traumatic experience, the people of both Karnataka & Maharashtra experienced on the early morning of 30th September 1993. It is a ghastly experience for the people but it is a news to us. We are sure we do not have the total picture of the damage that occured to the properties, lives and other belongings, except what Government and the media have projected in the official circles. You must be eagerly awaiting to have a vivid account of the total collourness.

We are glad that Mr.Ramappa C.Hadli, Programme Co-ordinator, as a VHAK representative visited the affected places, met people from different walks of life and background and collected the information personally and the same is complied. The copy of this report is enclosed for your first hand experience.

We are also pleased to inform that a four member team comprising representatives from both VHAI and State VHAs (MPVHA & UPVHA) undertook an on the spot assessment during the first week of the onset of the disaster and suggested the following that VHAI can take up:

1. Identification of specific needs of two selected clusters of affected villages receiving inadequate assistance.
2. On going monitoring of interventions and strategies being undertaken by State agencies in order to identify specific grievances and channelise resource distribution at local levels.
3. Identification of specific long term health interventions eg. physical/mental rehabilitation in selected areas to be based on the lacunae in the present modus operandi.
4. Mobilisation of required resources among member institutions and other professionals to facilitate targeted field operations.
5. On going dissemination of primary and secondary information to State VHAs, member institutions and others.

LOGISTICS

In order to operationalise the above recommendations suggestions for the development of a targeted strategy for disaster management at three levels are as follows:

A. Resource/Information Centre: Location: Sholapur

Major possible functions

- Identification of interventions, plans and strategies undertaken by NGOs and International agencies.

.....2

- Collection, analysis and dissemination of primary and secondary information.
- Liaison with govt. and other agencies to follow-up local grievances
- Co-ordination of activities based on selected field level health interventions eg physical/ mental rehabilitation.

B. Field Centres

1. Taluk level (One)

Location: Omarga, Osmanabad District

Major possible Functions

- Orientation and training activities for community volunteers.
- Physical arrangements for personnel (volunteers, professionals etc)
- Liaison with district collectorate, volags and others
- Co-ordination of community volunteer activities
- Compilation, assessment and feed back of primary data
- Development of resource materials for community education (housing, causes and effects of earth - quakes, mental health, local traditions & practices etc).

2. Village level (Two)

Location: in two selected clusters of villages needing immediate attention

Major possible functions:

- Identification of beneficiaries in neglected villages
- Selection and supervision of community volunteers
- Liaison with Gram Sabhas and other agencies
- Referrals and identification of health services (Physical + mental rehabilitation) and other immediate assistance like agricultural requirements etc.
- Identification and registration of grievances and channelising distribution of relief supplies
- Provision of need based assistance e.g. writing applications, identification and resettlement of relatives, injured cases, registering grivances etc.

Hence, in view of the above massive task that VHAI proposes to emrark, VHAK wishes to join hands with VHAI. Through this letter it is our earnest request 'TO ACT NOW' by donations, contributions, help etc. which is feasible to you.

We solicit your kind co-operation.

Thanking you,

Yours Sincerely,

Neerajakshi

(T.NEERAJAKSHI)
Promotional Secretary

VOLUNTARY HEALTH ASSOCIATION OF KARNATAKA

REPORT OF THE EARTH QUAKE

Man in the desire of conquering Earth, Sky, Air and Water has denuded nature beyond limits, without thinking of the consequences of such a venture which is the root cause for many untold miseries and ills. People are of the opinion that nature has punished her own children through natural calamities. It appears true, though it may be considered as, blind belief as human greed has resulted in many Disasters.

The above statements were expressed by Co-travellers when I was travelling in the bus from Bangalore to Bijapur. Discussion about earth quake has become the talk of the hour.

It was a grieving experience to personally witness the earth quake disaster who had till then just read in News Papers etc., heard in Radio and seen on the T.V.Screen about vehicle and train accidents and plane crash. It is difficult to express in words the calamity.

The September 30 earth quake which drew the attention of not only India but the whole world is the worst ever catastrophe to hit the country in recent times, as the earth quake ripped through Central Maharashtra region early on Thursday morning and turned cluster of villages into graveyards. It has not only struct 73 villages of Lathur and Osmanabad districts (Marathawada region) of Maharashtra State but also the 25 villages of Bijapur, Bidar and Gulbarga, border districts of Karnataka State.

History of Earth Quake:
The above Earth Quake is the fourth in this decade - above 30,000 lives have been lost.

During the earth quake of 20 October 1991 at Uttara Kashi nearly 1,500 were killed and thousands of them wounded. The intensity of the quake was 6.1 on Richter Scale.

- In the Bihar earth quake of 20 August 1988 more than 1,000 people died. The intensity of the quake was 6.5 on Richter Scale.

- The earth quake during the year 1967 in Maharashtra and 1905, 1975 & 1987 in Himachal Pradesh resulted in loss of many cattle and human lives.

OPINION: Reasons for earth quake expressed by the Mass are varied. Due to the advancement in science, computer horscope,

information pertaining to share business, likewise cyclone, floods & femine can be predicted. But we cannot forecast earth quake or be aware of callousness. Hence, such disasters strike suddenly. Many may say that they were aware but none could perdict this. Though not exactly, the people were expecting this disaster cannot be ruled out. The reason is that from the last two years people were experiencing slight tremors now & then, within a span of three months i.e. between August - October 1991, 300 times in a day is a common news. Expecting the earth quake the local people approached the Government to provide them alternate place (shelter) several times but in vain.

On the other hand after the devastation both Government and Voluntary Organisations speak about relief, rescue, compensation, rehabilitation etc., but everything is in a state of confusion as none of them have defined policies & programmes. It is obvious that the compensation is not given to the victims though it is announced in News papers. In this regard Karnataka Government has atleast disbursed meagre interim relief fund. But the declared amount of compensation by the Maharashtra Government is not given but adequate water, milk and food are supplied. The Government with its stringent policies is aggrevating the sufferings of the victims.

CHALLENGE: Rehabilitation of the victims of the Disaster is a challenge to the Government and the society. Many problems such as supply of enough food, safe drinking water, providing medical aid, education etc., are the immediate needs. It also encompasses the basic necessities of the people. Such a situation demands Rehabilitation of the victims, patients and future of remaining adults and children. Efforts should be made to provide all the basic facilities and mobilise resources for the same which is a great challenging task of the future.

ASSUMPTIONS & FACTS: It is a common phenomenon that Why and How the earth quake struck is being discussed. Earth quakes are caused by a variety of factors including the structure of subsoil, presence of faults and rock formation. But many of them attribute that lack of scientific planning while constructing reserviors around Koyna dam had been a major cause of the earth quake which claimed thousands of lives. People also believe that this may be the result of large number of borewells dug within a distance of 20-30 metres.

30TH SEPTEMBER DISASTER: Ganesha festival in Maharashtra is celebrated with great pomp and rejoice. People had returned home late night after the immersion (ceremony) of the Ganesha idol and had gone to their bed. Before they could go to sound sleep, many of them went to deep sleep never to awake again due to Eqrth Quake on 30th September early morning at 3.56 a.m. the first tremor with a loud noise was experienced. The intensity was 6.29 on Richter scale that lasted for 45 seconds. The subsequent tremors i.e. second at 4.41 a.m. (54 seconds) third at [illegible] a.m. (12 seconds) fourth at 6.34 a.m. (22 seconds) and fifth at 7.45 a.m. (2 seconds) were experienced and at several places thrice again at 9.30 a.m. 9.40 a.m. and 2.24 p.m. has been reported. It is ghastly scene to witness the devastation in nearly 73 villages of Lathur and Osmanabad districts.

AFTER DISASTER: Aid was provided two days after the disaster which took place on 30th September 1993. The people of Pethsanghvi feel sorry and are of opinion that many more lives could have been saved if the relief (AID) was rendered immediately. Vivekananda Medical Foundation and Research Centre - Lathur was the first organisation to arrive and extend immediate help to the injured. After two days, Army, Railway employees, Voluntary Organisations etc., from Maharashtra and other parts of the country arrived and took active role in the relief work. It is gratifying to note that the Maharashtra Police, Army and Railway employees were actively involved in clearing the debris and extricating the bodies.

Though the relief work is hastened to a great extent by resources pouring in from various parts of the country and abroad in the form of cash, food, clothing, medicines etc., there was no proper disbursement of the same. The tents from America were not seen except in two or three villages where it was used as school shelter, likewise, it was astonishing to learn from the school master of Pethsanghvi that thousands of woollen blankets arrived from Germany had not reached needy people. However, the first stage of the relief work was continuing smoothly.

UNTOLD STORIES: Though the relief work is carried out on a war footing the major portion is done by Maharashtra Government. Initially few Quasi Govt. and voluntary organisations were engaged in the relief work and later when large number of organisations joined, Govt. had to impose restrictions to entry around 30 kms radius without prior permission. In

spite of the massive presence of the army and the police; looting of valuables from the debris was rampant, after the sun set both villagers and army personnel leave the place and miscreants gain entrance under all guises, including that of relief workers. Mr.Vishnu churilal Naroji is clawing through the debris to retrive whatever possible. He personally shared that his brother's 25 sovereigns of gold and cash of Rs.22,000/- were missing. Many more such instances have occured since Police also indulged in such crimes. Hence, the local Marathi daily newspaper SANCHAR (7.10.1993) had published that 75 police were suspended by Maharashtra Government. There was a rumour that nearly 150 police have been suspended till now besides a Talishadar and his assistant.

In the two districts of Maharashtra 46 and 21 villages; (Umarga taluk 28, Osmanabad taluk 18 villages of which 15 villages have been flattened and in the reamining 31 villages the intensity of damage is less.) In villages where the damage is less the houses are unsafe for living and the extent of damage is yet to be assessed.

Besides damage to the property the number of lives lost in this disaster, Killari village contributes the major toll (90% of both life and property). Hence it has drawn the attention of most of the organisations both from the government and voluntary organisations thus depriving other villages of their services, which resulted in further loss of lives. The neighbouring villages of Killari, Pethsanghvi Kavata, Narangavadi and Sastur have been neglected. This fact was expressed by the villagers personally when we met them. Dr.Mukunda Rao Sindhe of Petesanghvi who had lost 4 children out of 6 in the cetastrophe, though engaged in offering services to others feels extremely sorry that many more lives could have been saved if timely services were rendered. But it is disappointing to note that some of the leaders were engaged in Groupism.

CASTE POLITICS: Petsanghvi was a small neat village of 4000 population and there were 800 houses, one fourth of the population were Muslims. Though some of the victims are provided with temporary sheds on the main road, few of the Muslim community victims have been given temporary sheds on the other end of the village where water supply and street lights hardly exist. Hence Muslims feel they have been seperated and neglected. During the interaction with

Sri Dilip Rao Moule it was learnt that the Muslims are disappointed and have been questioning this attitude, though appears to be simple but may further lead to communal disharmony. It was surprising to see that the only house to have survived the quake is that of Sarpanch Dilip Rao Moule.

Government and the Voluntary organisations have undertaken massive relief services to the victims. One of the important area is disbursing monetry compensation. It could be observed that castism was important as the leaders of a particular caste were interested to get the same for their people.

There was no unity and trust among the villagers and each one is suspicious of the other and this is being exploited by politicians and caste leaders. This may grow strong further and be an obstacle in providing the relief in future.

IMMEDIATE WORK TO BE UNDERTAKEN: We may need another 3 months to arrive at a total picture of gravity of loss occured. Immediate relief is temporary relief. Hence, an intensive survey of the area has to be undertaken to disburse monetry help to victims immediately. Otherwise, people will lose faith and trust in Government and its officers, the whole issue will become political and solution to the problems may not be forthcoming in the near future.

Compensation announced by the Government is still remaining in the form of declaration. People approaching the concerned officers along with their caste leaders for compensation is a common sight, which has given room to dis-satisfaction among all sections of the society. Hence the government should take immediate steps to resolve all the issues.

RELIEF WORK: Indian army and some of the organisations have returned after helping in extricating the dead, clearing the collapsed houses and saving the belongings for the claimants to the extent possible. Many of the injured victims undergoing treatment at private Nursing Homes, Vivekananda Medical Foundation and Research Centre and Government Hospital at Sholapur are recovering. The helping hand extended to Government and the services rendered by the Voluntary Organisations from all over the country and globe is appauled by everyone. However, counselling and remedying the trauma is challenging task to both Government and Voluntary Organisations. It is important to make people realise that Earth quake is a Natural calamity besides providing relief, relocating, helping in resettlement and counselling to start

new lease of fresh life.

AID: Several countries have joined the United Nations and International Voluntary Organisations in offering assistance for rescue and relief operations to the victims of the devastating earth quake, besides from the various parts of the country.

1. World Bank has sanctioned $300 million, to be returned on easy instalments. Survey of the area was carried out by the World Bank.

2. European Financial Community has committed to extend their help after getting complete report of the devastation.

3. UNICEF has provided Rigs and Pumps to dig new bore wells in the resettlement colonies.

4. Kerala Government has decided to adopt one quake hit village for total development. Also, International Lions Club has adopted Kavara village.

5. Indian Red Cross has sent cotton blankets and rations with other materials needed for the victims.

6. All the State Governments of our Country have extended help in terms of Cash, Medicine, Food grains etc., besides free Medical aid and Volunteers provided by Voluntary Organisations.

7. U.S.A. has supplied 950 tents and 2.6 million sq.ft. of shelter material and medicines, similarly German Government has given wollen blankets.

Inspite of help extended from abroad and within the country it is disappointing to note that some of the villagers have not received any help till now. Other villages are neglected as everybody's attention is centred round Killari. Nearly 75% have not got aid despite announcement in the media. To cite an example the immediate neighbouring villages of Killari, Petsangvi and Sastur have not got temporary sheds, yet the reasons expressed are:

a. Lack of Co-ordination: Though Army, Police, large number of Voluntary Organisations and different Government departments worked with the same objectives, lack of Co-ordination led to utter confusion and chaos. The visit of police, politicians and political leaders hindered the relief work hampering operations by their very presence. This was

admitted by the Government officials who expressed their helplessness. There was no method to the madness brought in by the relief agencies. Many relief agencies, loaded with perishable food items were halted outside the villages for lack of permission by the officials. No proper system of disbursement of relief supplies was followed. As a result, many a survivor received items for which he had no need.

b. Current situation: Rumours about earth quake to take place in the near future and slight tremors experienced now and then has created panic among the already numbed survivors. People whose houses are intact are not courageous enough to stay inside the houses. Hence, we can see people of Lathur Umarga towns sleeping in the temporary tents erected in open air outside. Victims of the earth quake are yet to overcome the mental shock.

Even the volunteers of some Voluntary Organisations are assailed by the prospect of another earth quake hitting the area. In petasangvi some rescue and relief workers are showing disinclination to stay on at the relief camp during night.

DEAD BODIES AWAITING CREMATION: It is horrifying to see heaps of burnt bodies, here and there relatives searching the corpse of near and dear ones is a pathetic condition in 25 villages in and around Killari.

Macabre scenes of bodies being cremated on road sides, in the fields on top of debris or just about any place dot the land scape. Some collected the Wooden supports - Windows, doors, frames of their dwellings and used them for the pyre.

Though Army men dug through heaps of rubble to spot the dead and removed thousands of dead bodies, the villagers are of the opinion that many more are yet to be extricated. Dr.Pad salagi Sarpanch of Killari affirms that many more dead bodies are still left in the debris.

None are aware of the exact death toll due to quake. Government's estimation has not crossed 30,000 but the local people are of the opinion that it is more than one lakh. This figure is endorsed by Voluntary Organisations also.

According to Dr.Padasalagi Sarpanch of Killari nearly 50 - 60 thousand bodies are under the rubble. The details of the figures published in the Maharashtra times (Marathi daily) on 13.10.1993 is as follows. In reality, besides the details of 66,400 dead the unearthed bodies when counted (not to be found) would cross more than a lakh.

Name of the Village	Percentage Victims	Population of village according to 1991 census	No. of persons alive	No. of dead (Not to be found)
UMARGA TALUK				
1. Lohara	50%	20,000	19,000	1,000
2. Kanegaum	75%	5,000	4,500	500
3. Jevalli	60%	8,000	6,000	2,000
4. Kasti	50%	2,000	1,800	200
5. Sayed Hippuraga	35%	5,000	4,900	100
6. Anigoor	25%	15,000	14,000	1,000
7. Sasthur	60%	12,000	10,000	2,000
8. S.B.Chincholi	75%	800	200	600
9. Rajegauva	95%	2,000	500	1,500
10. Petsanghvi	80%	5,000	1,000	4,000
11. J.Holi	75%	4,000	1,500	2,500
12. Tavasigad	80%	3,000	1,000	2,000
13. Udatpur	75%	1,500	300	1,200
14. Makani	25%	6,000	5,500	500
15. Kavatha	50%	5,000	3,600	1,400
16. Yekkundi	60%	6,000	2,000	4,000
17. Kondavigad	55%	1,500	500	1,000
18. Salegaum	35%	4,000	3,500	500
19. Toramba	50%	2,000	1,500	500
20. K.Limbala	50%	5,000	4,500	500
21. Samudal	60%	1,500	500	1,000
22. Naijakur	75%	10,000	8,000	2,000
23. Narangavadi	60%	5,000	1,000	4,000
24. Kaladora	55%	2,000	1,500	500
25. Hvanthal	40%	2,000	1,800	200
26. Bori	50%	1,500	1,000	500
27. Matola	60%	6,000	5,000	1,000
28. Murshidapur	50%	2,000	1,500	500
		1,42,800	1,06,100	36,700
QUSA TALUK				
1. Killari	90%	18,000	1,000	17,000
2. Killariwadi	80%	1,000	200	800
3. Talani	100%	5,000	500	4,500
4. Gubal	70%	1,500	500	1,000
5. Nimbal	70%	3,000	2,000	1,000
6. Panegam	60%	1,500	1,000	500
7. Mangarool	50%	5,000	4,000	1,000
8. Nandurga	60%	2,000	1,500	500
9. Naregaon	40%	3,000	2,500	500
10. T.Chincholi	55%	1,500	1,200	300
11. Javalaga	60%	2,000	1,800	200
12. Lamjana	50%	5,000	4,500	500
13. Gajarakheda	60%	2,000	1,500	500
14. Sankhala	45%	1,000	800	200
15. Sarani	60%	1,500	1,200	300
16. Ujani	50%	5,000	4,500	500
17. Malavana	40%	2,000	1,900	100
18. Ashiva	50%	1,500	1,200	300
		61,500	31,800	29,700

EARTH QUAKE IN KARNATAKA

The most disastrous earth quake of the century that devastated many villages of Lathur and Osmanabad districts of Maharashtra left a trail of destruction in Northern Karnataka claiming 13 lives. Also in Northern Karnataka the border districts - Bijapur, Gulbarga, Bidar and Raichur were affected severly. The difference is that, in Maharashtra thousands of lives were lost, but in Karnataka more than 40 villages in the above mentioned districts have shattered hundreds of houses into rubbles. Though people all over the state felt the early morning quake, it was only in some parts of Northern Karnataka that it brought extensive damage to life and property. The death toll is 13, atleast six of them in Bijapur alone two persons each were killed in Bidar and Raichur districts respectively. Though many villages have been severly affected it is unlucky that it has not drawn the attention of neither Government nor Voluntary Agencies.

The September 30th catastrophic earth quake which struck around 4.00 a.m. has created havoc in the taluks of Indi. Mudhol, Jamakhandi and Muddebihal in Bijapur district, Aurad, Basavakalyan and Bhalki taluks of Bidar district and Alanda taluk of Gulbarga district, 29 villages of Bijapur have been damaged with a maximum death toll of 6 over 60 persons were injured, several of them critically injured are under-going treatment at Government Hospital- Sholapur. Many of the villages in Karnataka are awaiting relief services.

BIJAPUR DISTRICT: Severly affected district in Karnataka. Dhoolked, Umarani, Padekenur etc are totally flattened, out of the total death toll of 13 in Karnataka 6 were in Bijapur (Umarani - 2, Chadachan - 1, Bakeloni - 1, Padekanur -2). More than 1000 houses have been badly damaged and nearly 4000 houses are partially damaged. Likewise in Bikeloni, Chadachan, Jamkhandi, Taddevadi etc villagers were shelterless, In Dhoolked village over 150 houses collapsed and several persons were injured, two of them seriously. While 40 houses were damaged in Pandanur village of the taluk, 20 others were flattened in Chadachan village, 4 houses collapsed in Janawada and four more in Jagadele near Banahatti. Several persons were injured in the house collapses in Jagadale.

Though the death toll is negligible when compared to Maharashtra, damage to property is beyond estimation. People have left villages and are living in open air. They are scared to go back to their houses. Some are of the opinion that they would build their own houses if somebody provides

them land free of cost. Government is silent by just providing 6 zinc sheets for re-settlement. What is the future, is a big question hanging on their head.

GULBARGA DISTRICT: In many villages which are just 25 - 30 kms from Killari that drew attention world wide, such as Khajure, Gaddegoan and Alanga villagers are living on road side as nothing is left. Nobody is bothered though many days have lapsed after the disaster. The maximum damage to the property was in Jewargi taluk where 88 houses were shattered. The number of houses collapsed in other taluks of the district were 15 - Aland, 5 - Gulbarga, 16 - Sedam, 3 - Sholapur and 5 - Chincholi, 250 houses were collapsed or were damaged in total. Bhorga village is totally wiped out, though of late rescue and resettlement has been taken up. As some of the villages are totally neglected, earth quake has made them mentally depressed and lose hopes of life and security.

The story of Rudrawadi village of the same district is different. The continuous emission of smoke from earth has made people panic. Besides, Gulbarga district has experienced tremors 10 times. Hence, people sleep in tents in open air. People whose houses are partially damaged and cracked are scared that those houses may collapse any moment. This has made people come out of the houses in the late evening is a common scene. People feel it is continous, agonising mental trauma.

BIDAR DISTRICT: The reminiscence of earth quake damage can be seen in the villages of Ujallam and Illyala of Bidar District. A young man was killed when a portion of his house in Morkhandi village in Basavakalyan taluk collapsed. The tremors experienced now and then and the smoke eminating from the Earth in certain places has made people perturbed. The exact extent of damage is not known. At least 50 houses in Basavakalyana and Humnabad taluks have collapsed and 550 buildings are partially damaged according to Government estimation. Besides the houses which are completely damaged hundreds of houses are unsafe for dwelling.

In the major four districts of North Karnataka the cracked houses in many villages have deprived people of their right to live. They are under the fear of death. Added to this, economically weaker section of the people are living on the sheets. For eg:- Though the 150 houses of Gaddegoan village in Gulbarga district which is just 25 kms from Killari is flattened, but people are still hopefully awaiting relief,

compensation and resettlement. Even after 7 - 8 days after the disaster no relief until Minister Gopinath Sandra visited. It is unfortunate that Government has not realised that there are many Killaris in Karnataka also. When thousands of volunteers and voluntary organisations offered to extend their services at Killari, Government turned down their offer under the pretext that they would be informed later, had to return disappointed. But the appeal by people to the Government has not yeilded any result in Karnataka.

SOLUTION Nearly five to six thousand houses are damaged in four districts of Karnataka. The figures for the partially damaged houses are not available. The figures of Government registration and personal registration do not tally. The exact number is yet to be arrived at. With regard to relief, Karnataka is better. In Maharashtra people are running from pillar to post, but in Karnataka though the amount is less i.e. Rs.20,000 to each families who have lost lives, Rs.10,000 to each families whose houses have completely collapsed and Rs.500 for partially damaged houses. Ministers have visited the place and have expressed their grief, but what is the future?

Though 6 zinc sheets are distributed to each families whose houses were totally damaged the shelter is not enough and are scared that the sheets may fly off when a strong wind blows. People are totally confused.

RELOCATION/RESETTLEMENT: Though the Government has come forward to provide alternate land to build houses it has not confirmed the exact place. Hence in Dhoolked and Umarani villages the farmers are prepared to build their own houses provided free land measuring the dimension of their sital area is given. This is the demand from the youth to the Government. Government has agreed to build houses for the economically weaker sections but no one is aware when the process would be initiated by the Government. Sri Maruthi Patil of Dhoolked is of the opinion that there is lack of leadership to initiate the process among the villagers. This statement was also supported by Mr.Ashok Chinchili of Umrani village.

BAD ROADS: The condition of the Road is very bad with pot holes and also untarred which makes reaching the village very difficult. But with the visit of the Ministers to these places, scene has improved a bit. It is surprising to note that neitner Government nor voluntary organisations have

provided food, medical services, besides moral support. Government has not taken up any followup action after giving compensation amount. People have welcomed the Government's proposal of providing alternative land, but Government is delaying its implementation. The immediate action to be takenup by Government is to provide proportionately alternate free land, economic help to build houses and total development of the weaker section are the needs of the hour and hasten the process, otherwise the sufferings of the victims will be further aggrevated.

CONSEQUENCES AND SOLUTIONS:

1. Many children besides being the victims of earth quake disaster have lost parents, relatives, property etc and have become orphans. A thorough survey has to be undertaken and priority has to be given to their Health, Education and total development is very much essential. In such a situation everybody should share this responsibility.

2. The mental shock has created many problems. On one hand, there are cases of acute depression. Most survivors staring vacantly into space, powerless to speak, unable to cry, emotionally maimed. On the other some survivors have come to terms with the harsh reality, forced with the insecurity of tomorrow, with their houses destroyed, their belongings buried and their loved ones no more. To solve such problems psychotherapy and counselling are necessary. Hence psychiatrists are needed.

3. Nearly 10 to 15% of the patients in Umarga, Lathur and Sholapur hospitals are mentally depressed and shocked. Hence, it is important to treat such patients immediately.

4. Families who have undergone family planning operations and have lost all the children they had are desparate. A survey of such families has to be done and establish family counselling centres to overcome mental trauma, help and encourage them to adapt to the prevailing situation. Government and Voluntary Organisations have to come forward to conduct recanalisation operations free of cost to help such families have children so that new lease of life is started.

5. As many old people have survived the disaster, old age homes have to be established. Voluntary Organisation can play an important role in this regard.

6. Since, many of the above problems are related to mental health, it demands for the establishment of Mental Health

counselling centres in the earth quake affected areas to counsell them.

7. Above all it is very much essential to relocate and rehabilitate the victims who have lost property, houses and are helpless to lead a fruitful life in future.

Government, Voluntary Organisations, Medical personnel, Social workers, Service organisations and Volunteers have to strive and work collectively to bring a ray of hope into the lives of the victims.

FLOODS IN KARNATAKA

The people of Bijapur and other districts were regaining slowly their material, physical and mental trauma that were suffered due to earth quake disaster. In the meanwhile the rains which were expected during July - August, got delayed and people thought they would suffer from another natural calamity 'drought' without the seasonal rains. But to their surprise the rains lashed out very heavily between October 8 - 10 resulting in heavy floods. To the dismay and shock the people instead of thanking the "Varuna Deva" "Rain God" they had to curse the God as His boon turned out to be a bane to the society. The heavy floods have wiped out many a houses from the ground not even giving a trace of its original existence. The property, cattle, grains and all the belongings the people had accumulated with their meagre savings were completely wiped out. This has made people to suffer in silence. Nearly 23 people were left dead in floods, compared to 8 lives in the quake. The floods have disrupted the road, rail and telecommunication and people were isolated. Immediate and urgent relief was most essential to the marooned people. The Helicopters and Airplanes have to be pressed into service to air drop the food packets to nearly 20,000 people sorrunded by water.

These floods took away 11 lives in Bijapur 9 lives from Raichur, 1 in Bellary and 2 in Mangalore districts respectively in total 23 precious human lives were rendered dead due to floods. When we look at the district wise marroned villages which were surrounded by floods is 18 villages in Raichur taluk, 12 in Manvi taluk, 6 in Sindanur taluk and one Deodurg taluk, totalling to 42 villages were converted as islands. In Raichur district alone, it is estimated more than 5000 houses and countless number of huts were washed away. Similarly in Siruguppa Taluk in Bellary district 5500 houses collapsed, 800 huts were washed away, 50 irrigation pumpsets were submerged

in water. Similarly the damage in Bijapur district is no less compared to other districts. Here 2000 houses have collapsed, due to rains. When we look at the total loss/damage of housing property in these districts one can estimate that nearly 15,000 houses collapsed, 200 to 3000 huts submerged in water, and added to this lot of cattle and human lives were lost with their property. This shows that the damage due to floods were more than the earth quake in Karnataka.

All the lakes and ponds in the flood affected areas are full and are nearing danger mark. Devanpalli, Tuntapura, Mangalore, Nagalapura, Manslapur, Kereburbur, Deodurg, Nagoli, Khanapura, Honnatagi, Govindapalli lakes have breached and resulted in destroying the crops, The sunflower (commercial crop) cultivated in more than thousands of acres of land in Raichur district is completely damaged.

In Gulbarga district 300 houses have collapsed and thousands of houses are partially damaged. Since there was a maximum rainfull of 115 m.m and minimum of 25 m.m the sunflower and paddy crops in thousands of acres have been destroyed.

Continous 3 days rainfall in Bellary district has resulted in steep raise in eater level of Tungabhadra dam crossing the danger mark and the villagers living near the dam were cautioned. Total estimation of loss due to floods is around Rs.50 crores of personal property, Rs.20 crores of public property besides Rs.21 crores of crops (cultivation of 59700 hectares) 2000 housed ruined completely and 1.50 lakhs houses are partially damaged. It is estimated that loss due to house collapse alone is estima ted around Rs. 30 crore.

Floods is not new to Karnataka. Last year i.e. 1992 during the same season many of villagers were homeless due to floods in Raichur district. Till date no permanent steps/are taken to control floods in these flood prone areas except for dolling out little money as an interim relief, Government has failed to take precautionary measures to prevent such calamities/disasters.

THINGS TO BE DONE ON WAR FOOTING:

1. Immediate adequate compensation to the victims and bereaved families.
2. Guidance, financial help and materials at subsidised cost to those who want to build houses.
3. Technical know how to build strong & high roofed houses to people.
4. Above all compensation to persons who have lost houses, property, human and animal lives etc immediately.
5. Health services, Medical relief, Preventive programmes to control ensuing epidemics etc.,

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This Report is originally prepared in Kannada by Mr.Ramappa C.Hadli, Programme Coordinator & translated to English by Ms.T.Neerajakshi, Promotional Secretary - VHAK.

1992-93 is Rs.14,800/- and the amount sanctioned by the Trust is Rs.1,39,435.00.

ORATION:

Dr.K.S.Shadaksharappa oration was delivered by Dr.M.J.Gandhi during Internal Medicine course held at Bangalore Oct.1992.

DONATION:

During the year we were able to collect Rs.73,104.00.

We have purchased an Electrical Typewriter for Rs.9,500/-.

As you can see, our field of activities as increased and we are receiving applications for grant for research project as well as CME programmes from Dist. & Taluk, Head Quarteres. To fulfil these obligations we have to generate more in financial resources, I request the members to use their good offices to get more and more donation for the Trust.

I thank the various office bearers of Sister Associations and convenors of the various course for their help in conducting the CME programmes. I specially thank all the Trustees who helped and encouraged me in many ways. My special thanks are due to Dr.K.S.Shadaksharappa, the Chairman and Dr.K.Krishnamurthy Vice Chairman who are a source of inspiration to me.

(Dr.M.MAIYA)
Hon.Secretary

HRD in Health.

1. Education of the Health Team.

a. Statistical Overview and comparisons.
   — India Vs. Karnataka.

b. Inadequacies
   — achieved targets Vs. goals.

c. Comparison with other States.
   Regional variations in Karnataka.

2. Medical Education.
   a. History — Ramanagaram experiment.
   b. Govt / private
      Numbers; Numbers needed
      Ug / Pg; input / output; migration.

   c. ROME programme.
   d. Capitation fee
      SC decisions
      Case studies.
   e. An Alternative Curriculum
      SJMC, KMC, Bijapur (Box Item).

   g. ~~History~~.
   f. PSM Depts.
   g. Social Relevance.

3. Nursing Education:

a. Govt / Pvt.
Nos: not needed
B.Sc / certificate course / ANMs
Migration; attention (?)
Capitation fee.

b. Status problem → Doctors vs Nurses.

c. Community 'nursing' alternative.

4. Dental Education.
Govt / Pvt
BDS / MDS; I / O.
Capitation fees.

5. Pharmacy
Govt / Pvt; Degree / dip.; nos / nos reqd.

6. Paramedical Training.
X-ray, lab, dental, ECG others
food inspectors; physiotherapists / occupational therapy.
Nutritionists / dieticians.

TBAs — training from condescension to dialogue.
CHWs — The NGO pioneers
CHW scheme & evaluation — euphoria & disillusionment
CHW — Lackey or liberator.
Anganwadi workers — ICDS alternative
Alternative Pedagogy — helping HWs & learn.

7&. Continuing education of the Health team.

8&. A final comment.

— appraisal ; future scenario ;
recommendations → need for an change.
alternative pedagogy & plan for
manpower edn.

Sources.

1.a. Ref. Compendium of Govt. recommendations.
~~Eco. Survey 1992.~~
Draft VIII FYP. Dir. of Med & Nursing Edn.

2.a Prof (Dr) S.V. Ramana.

2.c J. Janakekal's thesis.
AAON.

2 d Relevant file.

2 e SJMC → St. John's file.

2 f PSM Dept. SVR, Drs. Ramakrishna, Shivaram & Achutan.

3. Ms. Sujata de Magry of INSA.
Lalita Kumari – SJMC
Sulochana Krishnan.

4. Dr. Srivastava.
Shankar Aradhya.

NG.

1. Status problem → Doctors Vs. Nurses.
   Ms. Sujata of INSA.
   ~~Dr.~~ Ms. Lalita Kumari of St. John's.
   Ms. Sulochana Krishnan.
2. Community 'nursing' alternative.
3. Training of Dais. HP Project.

Mental Health. NIMHANS.
Mohan Issac; Kapur

Traditional Medicine. ~~Dr.~~ SPT.

MSNC.

1. Statistical Overview → India vs. Karnataka.
   inadequacies → Ach. & Targets vs. goals.
   (Ref. Compendium of Govt., Recommendations.)
   Comparison with other States. And, regional variations within Karnataka.
   Ref. IMA
   Health manpower can also be included.

2. Med. Edn.
   a. ROME Programme
      (J. Parakkal's thesis & AADN).
      IJME
   b. Capitation fee. (See the relevant file).
   c. An alternative curriculum.
      St. John's → a box.
      KMC
      Bijapur
   d. → Helen's.
      MFC book on Med. Edn. in India.
      Prof. S.V. Ramarao.
      * Ramanagaram Experiment, → a box.
   e. PG Studies in medicine.
      (GOI) Directories on Med & Nursing — ask John.)
   f. PSM Departments — Ref. SVR. *
      ~~Dr.~~ Dr. Ramakrishna
      Dr. Shivaram
      Dr. Abdulla.

SC informed of errant colleges

IE 18/4/1

★★ BANGALORE — The Supreme Court has been informed of the Manipal and Ramaiah groups' refusal to admit students selected in the Joint Entrance Test (JET), it is learnt.

However, the Court has not issued any direction in this regard so far. The students allotted to these colleges have been admitted at the Directorate of Medical Education and will be considered as having got admitted to the respective colleges. •ENS

More free seats in professional colleges

HINDU
13/XI.

From Our Special Correspondent

BANGALORE, Oct. 12.

The Chief Minister, Mr. M. Veerappa Moily, has announced a quantum jump in the number of free seats available in medical, engineering, dental and other courses in both government and private professional colleges in the State and said the State Government was making every effort to abide by the Supreme Court Judgment.

Speaking to presspersons here on Tuesday, the Chief Minister said the number of seats under the reserved and merit category had vastly increased during the current year following the drastic reduction in the number of seats under the capitation-fee quota. The Supreme Court in its latest order dated October 7 has permitted the private professional colleges' managements to admit 15 per cent students under the Non-Resident Indian quota while the admission under the remaining 35 per cent of the payment seats quota and the 50 per cent merit seats quota remains vested with the Government.

Mr. Veerappa Moily said the number of medical seats available under the payment and merit quota falling under the purview of the Government this year had increased to 1862 compared to 859 seats last year. In the Scheduled Caste category, the number of medical seats had increased to 280 from 129 and in the Scheduled Tribe category the seats had increased to 56 from 26. In the field of engineering education, the number of seats had increased to 10,823 from 6461 last year and the 15 per cent Scheduled Caste seats had increased to 1,623 from 969 and the three per cent reserved seats for the Scheduled Tribe category had jumped to 324 from 194 seats.

The Chief Minister said effective steps had been taken to ensure that the private professional colleges went ahead with the admissions as per the list prepared by the Government. Apart from sticking to the Supreme Court verdict the State Government had simultaneously implemented the reservation of seats for students hailing from a particular university jurisdiction in the colleges falling close to their hometown and the special quota for rural students. Steps had been taken to ensure that these reservations made out by the State Government did not work against the Supreme Court judgment. There have been no reports of the private colleges refusing admissions and they had apparently accepted the Supreme Court judgment, he said.

Last date for admission: The Supreme Court, Mr. Veerappa Moily said, had directed the State Government to take immediate and effective steps to ensure admission of students against all free seats and payment seats in all professional colleges on or before October 31 and confirm the same to the court. "Now that the legal position is absolutely clear, virtually all the colleges have started admission of the first free seat list students. The last date of admission for such students is October 12."

He said the first modified list and second list would be announced on October 18 and the last date for admission was fixed for October 20. The second modified and third list would be announced on October 26 and the last date for admission fixed for October 28. The third modified list and fourth list would be announced on November 1 and the last date for admission fixed for November 4.

Under the payment seats quota to be announced by the Government, the first selection list would be announced on October 15 and the last date for admission fixed for October 21. The second selection list would be announced on October 26 and the admissions as per the list would have to be completed by October 29.

Mr. Veerappa Moily said the Governor in his address to both Houses of the Legislature at the beginning of the budget session had announced the intention of the State Government to implement the Supreme Court judgment dated February 4, 1993, in the Unnikrishnan case. The State Cabinet in March 1993 approved the admission rules in compliance with the judgment.

The State Government thereafter conducted the Common Entrance Test and published the rank list on August 7 last. The free seat list was published on September 19 last excluding only those seats in minority institutions that had been specially ordered to be excluded by the court. "It is expected that the admission process will now continue smoothly and we shall be able to start the academic session by early November," the Chief Minister said.

Cabinet panel on fees in professional colleges

HINDU D/XI.

From Our Special Correspondent

NEW DELHI, Oct. 11.

A Cabinet subcommittee has been set up by the Prime Minister to study the norms governing admission and fees at private professional institutions.

Giving this information to members of the Parliamentary consultative committee attached to his Ministry, the Human Resource Development Minister, Mr. Arjun Singh, pointed out that the Supreme Court had laid down a scheme for regulating private professional colleges.

Mr. Arjun Singh told the MPs that the need for Central guidelines was underlined by the recent Supreme Court judgment. The Prime Minister had directed that the guidelines be formulated well before the next academic session.

Mr. Singh ruled out the possibility of privatising education. The Government was, however, encouraging institutions to raise their own funds in view of the resource crunch faced by the Government.

The focus of discussion at today's meeting was on the financing of higher education — the State's role and self-financing. Denouncing the capitation fee system, members held it responsible for the falling standards of education.

The meeting favoured merit-based admission, with an education cess on those who could afford to pay. It was essential to have two types of seats — free for the poor and deserving and paid for those who could pay.

The MPs also wanted a bigger role for the University Grants Commission in monitoring higher education in view of the vast expansion of the sector.

Stressing the need for reviewing the scheme of autonomous colleges, they favoured an increase in the intake capacity of the higher education sector.

The HRD Minister announced that another round of discussion would be held at the next meeting of the consultative committee.

Hearing on T.N. SLP adjourned

From Our Legal Correspondent

NEW DELHI, Oct. 11.

The Supreme Court today adjourned until October 25 a Special Leave Petition (SLP) from Tamil Nadu against that portion of the judgment of the Madras High Court delivered on July 27 directing the State Government to bring down the quantum of reservation to 50 per cent in admission of students into professional educational institutions before the academic year 1994-95.

The Bench consisting of the Chief Justice, Mr. M. N. Venkatachaliah, Mr. Justice S. C. Agrawal and Dr. Justice A. S. Anand also will take up on the same date for consideration, connected interlocutory applications (IAs) from Mr. M. Karunanidhi, DMK leader, Mr. K. Ramamurthy, president, TNCC(I) and Mr. Vadivelu, president, Janata Dal, Tamil Nadu seeking the court to implead them in connection with the hearing of the State SLP and other connected matter before the court in this regard. These three IAs pleaded in support of the continued reservation of 69 per cent in Tamil Nadu having regard to social and other relevant facts and circumstances obtaining in the State for the last few years.

A Special Leave Petition (SLP) from 'Voice (Consumer) Care Council' through its trustee, Mr. K. N. Vijayan (advocate) against the High Court's judgment and orders upholding the State Government's reservation in excess of 50 per cent for admission of students in professional colleges for 1993-94 was also adjourned till October 25.

On this SLP from 'Voice (Consumer) Care Council', the apex court on August 24, by its interim orders, restrained Tamil Nadu from making reservations in excess of 50 per cent for students of Backward Classes and other specified categories in respect of admissions into professional colleges (medicine and engineering) for the year 1993-94.

An important question among others, that has arisen in these cases relate to the implementation or otherwise of the Apex Court ruling in the 'Mandal Commission case' (in which the Apex Court had held that reservation should not exceed 50 per cent) by the Tamil Nadu Government in regard to admission of students into professional colleges for the year 1993-94 and also the interpretation by the High Court of the Apex Court ruling in the Mandal case in this regard.

End to capitation impasse imminent

JESIKI.

Aided colleges begin admission

EXPRESS NEWS SERVICE

BANGALORE

THE Supreme Court judgment on the capitation fee issue on Thursday has come both as a joy and a jolt to the thousands of students aspiring to get into professional colleges in the State. While on the one hand, an end seems to be imminent to the impasse, on the other, the fee structure has been increased exorbitantly, making it almost equal to capitation fee.

For medical courses, the State Government had fixed a three-slab fee structure of Rs 65,000, Rs 75,000 and Rs 85,000 annually while the Supreme Court has increased it to Rs 1.4 lakh for colleges partly using Government facilities, Rs 1 lakh for those with own hospital and Rs 90,000 for colleges availing of Government hospital facilities, per year.

While the State Government had fixed a higher fee structure for colleges which did not have hospital facilities of their own, the Court has reversed this by granting a higher fee structure to colleges which have their own hospital. The Government thinking was that the underdeveloped colleges required more finance, while developed ones could raise sufficient funds through the hospital.

For dental courses, the State Government had fixed an annual fee of Rs 40,000 and Rs 50,000 depending on the facilities offered. The Court has fixed Rs 1 lakh for colleges with hospital facilities and Rs 90,000 for colleges availing of Government facilities.

There has been no change in engineering and free seat categories.

ADMISSION LIKELY: Though private college managements maintained a silence over the verdict, the indication is that they might admit students. Federation of Private Medical and Engineering Colleges Shamnur Shivshankarappa and Taralabalu Jagadguru Shivamurthy Shivacharya Mahaswamiji said they would comment only after they received an official copy of the judgment. While the private college management representatives are holding a meeting on Friday at 3 p.m. the mathadipathis of five major mutts in the State will meet at 11 a.m. to discuss the future course of action.

However, nine private aided engineering colleges and one unaided college have begun admitting students allotted to them by the Government.

Some management representatives said on the condition of anonymity that they were not averse to admitting students as the Court had permitted them to fill 15 per cent of the seats from among NRIs and foreigners. If these seats are not filled, local candidates can be admitted. "In effect, it means that the Court has conceded to our demand for a quota as generally these seats are not fully utilised by NRIs," a representative noted.

Even if this quota is filled by NRIs, the colleges stand to gain as NRIs are required to pay US $ 50,000 (roughly Rs 15 lakh) for the entire course in medical colleges and US $ 5,000 (Rs 1.5 lakh) in engineering. This is higher than the capitation fee collected earlier.

PAYMENT SEATS: The list of students selected under the payment seat category would be announced with in a week, a senior officer in the Directorate of Technical Education said. The list was ready and the Government was waiting for the Supreme Court verdict, he added.

There was no immediate proposal to extend the last date of admission for students selected under the free seat category beyond Oct. 11. To avoid heavy rush on the last day, colleges would be directed to remain open on Saturdays too.

The State Government has been directed to send the list of defiant colleges to Supreme Court Judge S.R. Pandian for further action.

SC gives 15 pc quota to private colleges

ENS LEGAL BUREAU

NEW DELHI

THE Supreme Court on Thursday gave the managements of private professional colleges throughout the country the bounty of a 15 per cent quota for admitting students at their own discretion in the academic year 1993-94.

This order in effect gives the managements the right to fill up 15 per cent of their intake capacity with Indian students, who are not allotted to their colleges by State Governments on the basis of entrance examinations, in case of non-availability of Non-Resident Indians or foreign students to fill up the seats.

This "special provision made only for this year, being a year of transition" - since the Union Government is examining its own policy of a 50 per cent quota for foreign students for the next academic year - marks a major inroad into the five-judge bench judgment in the Unnikrishnan anti-capitation fee case. In that case the apex court, to put a stop to all malpractices by private managements, had refused to give any quota at all to the managements.

Justices S.R. Pandian, S.C. Agarwal, S. Mohan, B.P. Jeevan Reddy and S.P. Bharucha passed the order while rejecting Solicitor-General Dipankar Gupta's plea for a "status quo" this year permiting a 50 per cent quota for foreign students in the private colleges in terms of the Union Government's policy which is being examined *de novo* for the next academic year.

However, none during the arguments by the Union Government or the private managements had argued that the foreign student quota, if not filed up, be made available as a discretionary quota to the private managements. It had been clearly pointed out that only two medical colleges in Karnataka attracted the maximum number of foreign students and that too Malaysians. The rest did not. Hence the 15 per cent quota granted by Thursday's order for foreigners will effectively be filled up by Indian students at the discretion of the managements. Thus the key principle enunciated by the Supreme Court in its earlier judgment in the Unnikrishnan case that merit and merit alone shall be the criteria gets a knocking - at least this year - by today's judgment.

Former Attorney-General K. Parasaran had argued before the five judges that "some quota" be given to the private managments as even an honest honey extractor likes to lick his fingers and thereby have some taste of the honey. Parasaran was arguing for a private college in Tamil Nadu. The court in its order today has noted that the Kerala scheme which had not been brought to their attention earlier allowed managements to admit students of their own choice to the extent of 15 per cent.

The judges held that the demand of the private colleges that they should be permitted to admit 50 per cent of the students of their own choice "cannot be and shall not be conceded." They also made it clear that whatever might have been the circumstances and reasons for which the Government of India had permitted the private medical colleges to admit foreign students to the extent of 50 per cent, "it is clear that the said permission or arrangement is not enforceable and cannot be enforced with effect from the academic year 1993-94, in view of the judgment in Unnikrishnan case." They concluded: "Admittedly there is a crying need for these seats within the country itself and it is they who must have the priority in the matter of admission to these colleges."

Fee structure fixed

ENS LEGAL BUREAU

NEW DELHI - A five-judge bench of the Supreme Court on Thursday fixed provisionally the fee to be paid by students for admission to payment seats of private professional colleges in the country.

For medical colleges having their own hospital the fee would be Rs 1.40 lakh per student per annum. It would be Rs 1.20 lakh for colleges partly using their own and partly a Government hospital while Rs 1 lakh has to be paid for colleges using entirely Government hospitals.

For dental colleges the fee would be Rs 1 lakh per annum for those having their own hospital and Rs 90,000 per annum for colleges availing of the Government hospital facility.

For nursing and engineering colleges the fee fixed by each State Government would operate. All thes fees would be subject to final adjustment against the sums determined by the Union Government or the professional bodies (like the Medical Council and the All India Council of Technical Education) before the beginning of the next academic year.

▶ Aided colleges begin admissions – Page 3

▶ SC rejects plea to admits Malaysians; State rapped for trying to explain away inaction; Admissions open to engg colleges – Page 11

The judges held that the Karnataka Advocate-General's plea that the NRI fees be taken into account while laying down the fee structure is a relevant factor but not significant for the tentative fees to be determined for this year.

The fees have to be determined ad hoc for this year since the admission of students has already been delayed extensively and the Union Government as well as the professional bodies will finish their exercises in this regard only around the next academic year. Though the sums fixed for this year may seem to be high, the judges pointed out that the payment seats are only half and it is these seats that have to bear the entire burden of the expenditure incurred by the colleges, as 'free' students admitted on merit pay only a nominal fee.

Now that the fee structure has been fixed and the managements of private colleges have been given even a 15 per cent quota for this year, the judges have directed that all students be admitted to the free and payments seats on or before October 31, 1993.

USA / The one fear that consumes the middle class is that of getting ill or becoming unemployed

New health policy has ambitious goal

The costs of medical treatment in the world's richest country are enormous: a fracture: $10,000; a heart surgery $100,000; organ transplant $300,000

THE last socialist revolution may yet come from the biggest capitalist country of all, when health care is made available to all in the United States.

And yet the irony is that this revolution has been fuelled not so much by concern for the poor and the uninsured as by the fear of the middle class that it would lose medical insurance, for whatever reason.

The one fear that consumes the middle class is that of getting ill or becoming unemployed. Faced with hard times dominated by layoffs and unemployment, developing a health "condition" like heart disease or cancer, or even getting a divorce, would be ruinous.

As many as 25 per cent of all Americans are either uninsured or under-insured. Millions more live in dread of losing their insurance as they go through a personal crisis.

Last week President Bill Clinton set the ball rolling to reform the health care system so that everybody can get basic medical care. That the health care system was in need of drastic surgery has been evident for a long time. At least three Presidents, Harry Truman, Richard Nixon and Jimmy Carter, tried to reform it but were prevented by deeply entrenched interests and lobbyists who cried out that any change would endanger free market principles, encroach on the right of choice of the people, and would make way for more governmental interference in their lives.

Naturally, with market forces hijacking medical care, it went beyond the reach of the poor, and less of it was available to the middle class progressively. Ironically, even as medical research and technology achieved breakthroughs, finding ways of lessening the pain, new treatments, making more accurate diagnosis, etc., ordinary care became prohibitively expensive.

US suffers the ignominy of being the only industrialised country not to have universal medical coverage.

Consider the costs of medical treatment, regarded the best in the world, in the richest country: a fracture: $10,000; a heart bypass surgery $100,000 and an organ transplant $300,000. And yet the system ensured the insured person did not have to pay even a fraction of a treatment (it was done by the insurance company); and so overcharging, paperwork, unnecessary and expensive tests and surgical procedures, malpractice suits and "defensive" medicine, greedy drug companies and doctors hiked the costs of medical care.

The profits of drug companies were about $72 billion in 1992, and a doctor's average annual income $139,000 annually; specialists earned two-three times more.

As much as 14 per cent of the GDP is spent on medical care and is projected to increase to 20 per cent in the next decade. In real terms, America spent $752 billion in 1991 on health; in 1994, it is estimated to spend about $1 trillion.

On the other hand, Europe spends an average of 7 per cent and Canada 10 per cent, all of which have universal care. Monthly/quarterly premiums for a family have increased four to five-fold in the past five years and more and more people fell through the holes in the system to live with uncertainty and constant insecurity of a medical emergency hitting them and ruining their lives for ever.

According to a survey, over 25 per cent of the insured people fear losing it .

The increasing national bill for health care also drained resources from schools. It decreased wages as employers were forced to pay more toward insurance premiums, and of course increased the federal budget deficit.

Today, spending on Medicare and Medicaid programmes of the Government for the poor and senior citizens takes up 16 per cent of federal outlays and is expected to increase to 25 per cent. In 1965, this expenditure was a mere 2.6 per cent of the budget.

Mr Clinton decided to take the bull by the horns prompted by a public outcry for a cure which was first heard in 1991 when a Harris Wolford was elected Governor of Pennsylvania on the basis of a one-point agenda of health care for all, defeating Republican heavyweight Richard Thornburgh who had the backing of the then President George Bush.

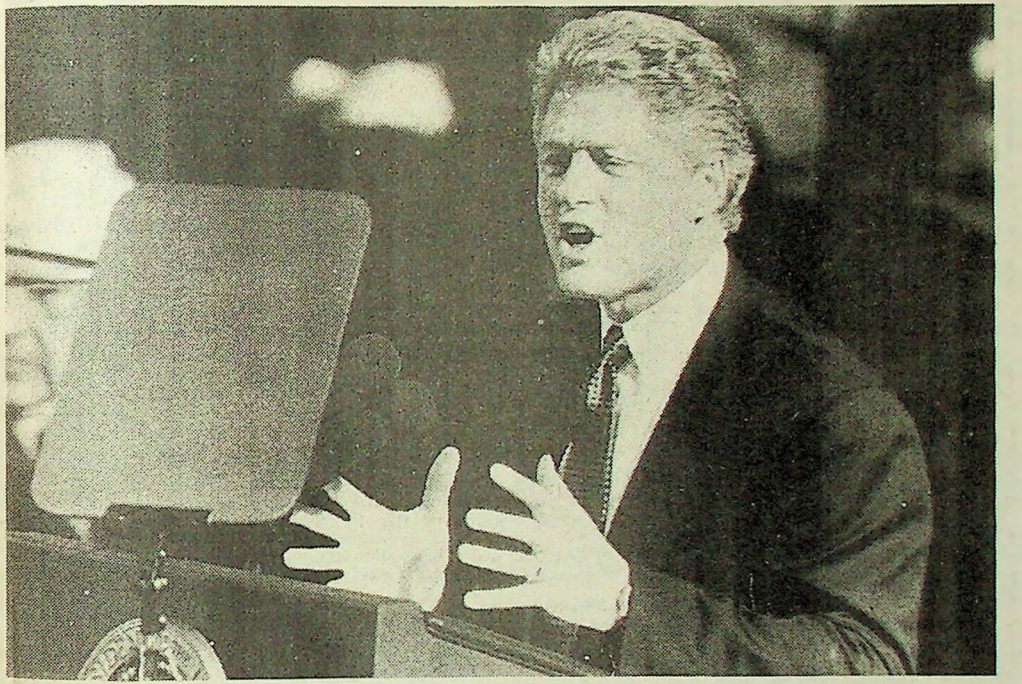
Mr Clinton adopted this agenda in his presidential campaign and on becoming President allotted the tough task to his wife, Hillary, to show both his commitment to reforming health care and his confidence in his wife's ability to tackle the problem.

The White House was deluged with letters from people who had horror stories to tell about their encounter with the medical system. As many as 700,000 letters came to the health task force. Seven months later, the broad principles of a programme have been announced with universal coverage as its cornerstone.

Several fears have been voiced: that those insured would have to pay more and get less so that others get coverage; that they would be burdened with more taxes; that bureaucracy and role of Government would increase. Worse, health care would be rationed. Needed care would be denied to control costs.

"Choice", one of the cherished American values, would be limited: certain procedures and facilities would be curtailed and patients may have not have the access to a doctor of their choice.

Mr Clinton and his team have launched a campaign, a little less than the magnitude of a presidential campaign, to sell the plan to the people, acquaint them with the details, remove their apprehensions and clarify their doubts. Or else, the lobbyists of drug companies, insurance companies and others who benefit from the status quo might run away with the programme.



Clinton makes big promises on being sworn in as President

And yet, they might as well be trying to convince the converted. Several opinion polls show that about 50 per cent of Americans want a total overhaul of the system; with another one-third seeking fundamental changes. Less than 15 per cent want minor changes in the system.

Mr Clinton has been hailed as a visionary; Hillary has been reinstated in public and media favour for her obvious dedication to people's welfare, especially the underdog. Both hope to carve out a niche in history but there is a long way to go before their vision takes a concrete shape.

The various committees of the Congress will debate and finalise the shape of the programme and finally vote the programme into law. Mr Clinton hopes to put the basic plan in place by 1995 and phase in the entire package by 1997. But, as a cynic would say, there is many a slip between the cup and the lip.

R. Akhileshwari
in Washington
DH News Service

MCBs ensure protection

P. K. Ranade

Electricity today is the most accepted and common form of energy and our government has laid great emphasis on its generation and distribution in all its plans. It is well appreciated that for the economic growth of our country the enhanced generation is a necessity.

Whereas on one side the efforts will be made to improve the generation on the other side still great efforts have to be put into development and manufacture of equipment which would help in distribution of power to the users. Hence the large scale application of power has necessitated the development of superior protection equipment like Miniature Circuit Breaker's which have over the years proved to be ideal solutions to meet with this important requirement.

With the extensive use of power in domestic, commercial and rural sectors the size of transformers used for the distribution have also increased. Whereas earlier one could use Rewirable Kit Kats for distribution of power, today because of the proximity of the big transformers these devices are unable to provide safety because of high fault currents.

Miniature Circuit Breaker's which are suitable for above application are based on the current limiting principle, these Circuit Breaker's clear the fault even in case of very high currents in 4 to 5

A dream from Parryware

All the current-carrying components of the circuit breaker are totally enclosed in insulated housing, which prevents accidents during normal operation. Even the user is safeguarded against dirct touch.

Mounting of the circuit breakers is now easily done on standard din channels where the circuit

generated which give a total protection against immediate high rust currents and sustained over load conditions.

Since the fault energy can be curtailed to pre-determined levels these MCBs are fully selective against HRC Fuselinks which can act as perfect back up protection which means circuit can break

ceeding 7 times the rated current; and these are also designed to withstand the starting currents of the motors.

The circuits allotted to groups of filament lamps that are to be switched on simultaneously, resulting in peak current at the time of switching on can operate magnetic tripping system of the

and switching capacity in coordination with the size of the transformers. The short circuit release has to be between 3 to 6 times the rated curent when switching transformers and the making-current of the transformer at no-load must be taken into consideration. Here again, the short circuits levels of the entire system have to be clearly defined in order to avoid damage to the breaker by installing a suitable HRC fuselinks as back-up protection.

Some breakers are extensively used for low voltage generators used in Marine spplications and also in captive generators in various industries. The expected fault current, which is of an asymetric nature, normally seen in practice, is above 6 times the rated current of the generator; and in majority of cases, even above 7 times the rated current, the generator is adequately protected.

Cables are reliably protected against overloads or short circuits by a circuit breaker equipped with magnetic and thermal systems compared to fuses. MCBs have the advantage of being ready to close again even on single pole overload and disconnect the lines on all poles; thus the lines on all the poles get protected against single phasing. The bimetallic system is duly calibrated to allow the rated thermal current and cut any

Vertical rise in Garden City

By Ali Khwaja

BANGALORE, ironically for a Garden City, enjoys an FSI which ranges upto 1.5 to 1.75 for residential buildings. This means that in a plot of 1,000 square metres, a total of 1,500 to 1,750 square metres of livable area can be built, on all floors put together. The permissible FSI does not include parking spaces, staircases and balconies.

Contrast this with the concrete jungle of Bombay. In that megapolis, the permissible FSI ranges from a low 0.75 to 1.0, and 1.33 only in exceptional areas. So is the case in many other metropolitan cities.

Despite this anomaly, Bangalore still appears to be greener and less congested than most other cities of comparable size. Those who ceaselessly complain of the monstrous constructions in Bangalore, and the destruction of the city's skyline and salubrious climate, have obviously not lived in other cities of the country.

While it is an undeniable fact that the Bangalore of yore offered vast open and shady spaces, that high tiled-roof bungalows did not need ceiling fans, and that greenery greeted the eye in every locality. Today, the position is far removed from what our grandfathers had reveled in. But then life itself has changed in all respects. Population explosion due to migratory influx has made every city stretch at its seams. Civic amenities are everywhere straining to cope with the parabolically increasing demands.

Thankfully the migration into Bangalore has been more of white collar workers and executives, rather than the mail workers and pavement hawkers who have invaded Bombay and Calcutta in the past few decades. Polluting industries have been kept away from Bangalore, and slums are few and far between. This has resulted in a comparatively planned and esthetic expansion.

It has also resulted in a fast increasing rate of demand for upper and middle class housing. Those moving into Bangalore, or moving out of their ancestral homes need comfortable houses in decent localities, but they certainly cannot afford even a fraction of the old colonial bungalow with its trellised windows and open verandas, laid out sedately in half an acre of lawn.

...It is an undeniable fact that the Bangalore of yore offered vast open and shady spaces, that high tiled-roof bungalows did not need ceiling fans and greenery greeted the eye in every locality. Today the position is far removed from what our grand fathers had revelled in. But then life itself has changed in all aspects.....

The need for providing housing could not be met by governmental authorities. The BDA, which started off well by providing thousands of residential plots in new extensions during the eighties, found itself buckling under the lengthening queues on the one side, and reducing land availability on the other. Predictably, it has been deluged under red tape and scandals. People applying for plots to BDA now do not stand a chance of getting an allotment within the next decade or two.

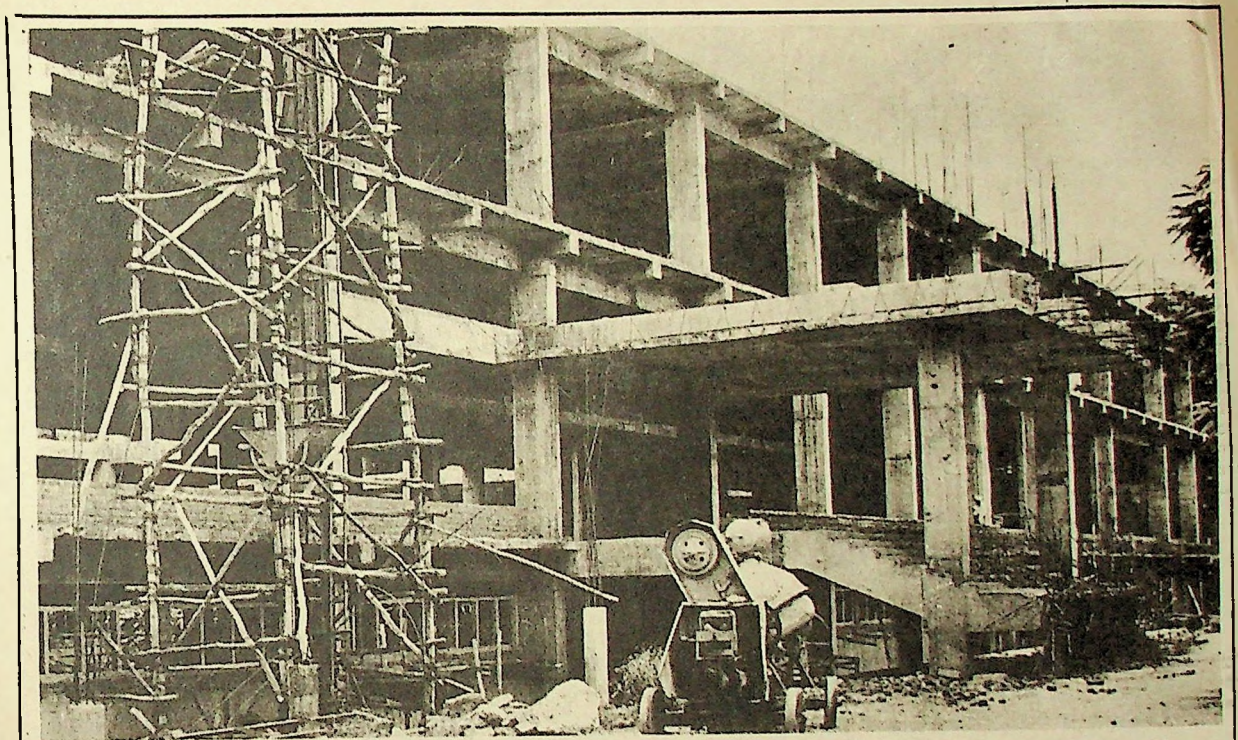
The Karnataka Housing Board also made valiant attempts at developing satellite towns around the city. Though it did meet with limited success, the satellite towns have not been entirely successful, as the housing layouts have not been supplemented with transport services, civic amenities, hospitals or schools.

The only source which has made some successful efforts at alleviating the dire shortage of housing in the city, has been the private sector construction industry. Dozens of local and migratory builders have been providing apartments at various locations to suit different budgets.

Although the rules of Bangalore City Corporation allow a higher FSI as stated earlier, the multi-storeyed buildings have been coming up with aesthetically designed and functional layouts. There have been stray cases of misdemeanours of fly-by-night operators, but they constitute a small percentage.

Most professional builders have taken pains to maintain colonial, Gothic, or traditional architecture. Greenery has been developed in open areas around the buildings, often by professional landscapists, and many plans have been altered to retain existing trees. This is the reason why Bangalore's multi-storeyed buildings, the only affordable housing in the heart of the city, are far better to look at, and to live in, than those in other cities.

The vertical rise of habitation is inevitable in all respects. More so in India where the traffic congestion and strain on civic services prevents people from living too far from their workplaces and schools. As long as the high-rise structures adhere to governmental regulations, and maintain a beauty and elegance, they should be encouraged rather than looked down upon.



Construction in the city never ends. Every year new structures come up, spoiling the sky line, robbing the city of its beauty. Trees are cut down to house these massive buildings.

B'lore turning concrete jungle

The City with a concrete skyline. This is the new name, Bangalore has acquired with concrete monstrosities dotting the once beautiful landscape. Old Victorian mansions are giving way to huge, faceless buildings.

Karnataka was always known as the bungalow country. Slow-paced gentle towns like Mysore, Mangalore, Dharwad and Bangalore were famous for their sprawling bungalows with tiled roofs.

The old bungalow culture is one of the casualties of progress. The highrise culture that is taking over was given a premature start by the Government itself when it put up in the Capital some of the ugliest buildings.

Some of them are not only aesthetically offensive monstrosities but also pose a danger to occupants because Bangalore does not have adequate high altitude fire fighting equipment and has frequent power failures which make lifts potential death traps.

However, this trend has been arrested after the collapse of Gangaram Building which killed about 100 people. Now builders have been forced to confine themselves to five storey buildings.

But it must be admitted that Bangalore's high rise apartments have at least some sort of aesthetic appeal compared to Bombay's match box structures. Even the Bombay builders have been forced to adopt higher standards in Bangalore. They have realised that this is the only way they can compete with established South Indian builders.

With a host of players operating in the City, there is little reason to doubt that both quality and aesthetics are key criteria for the success of any project.

Given the rising premium on land, the spread of apartment building is but natural. But what poses a major threat is the impunity with which laws are broken with official connivance. Consumer awareness is the best weapon to fight this. If flat buyers become more demanding in terms of quality and adherence to law, the standards of building industry may be maintained at an acceptable level.

For many occupants of high rise building it is the question of security, the absence of beggars and pestering salesmen. There are also no dacoities in such buildings as they are well guarded. Instances of robbery are also rare. But people who are used to living in independent houses definitely miss the open space and breezy atmosphere.

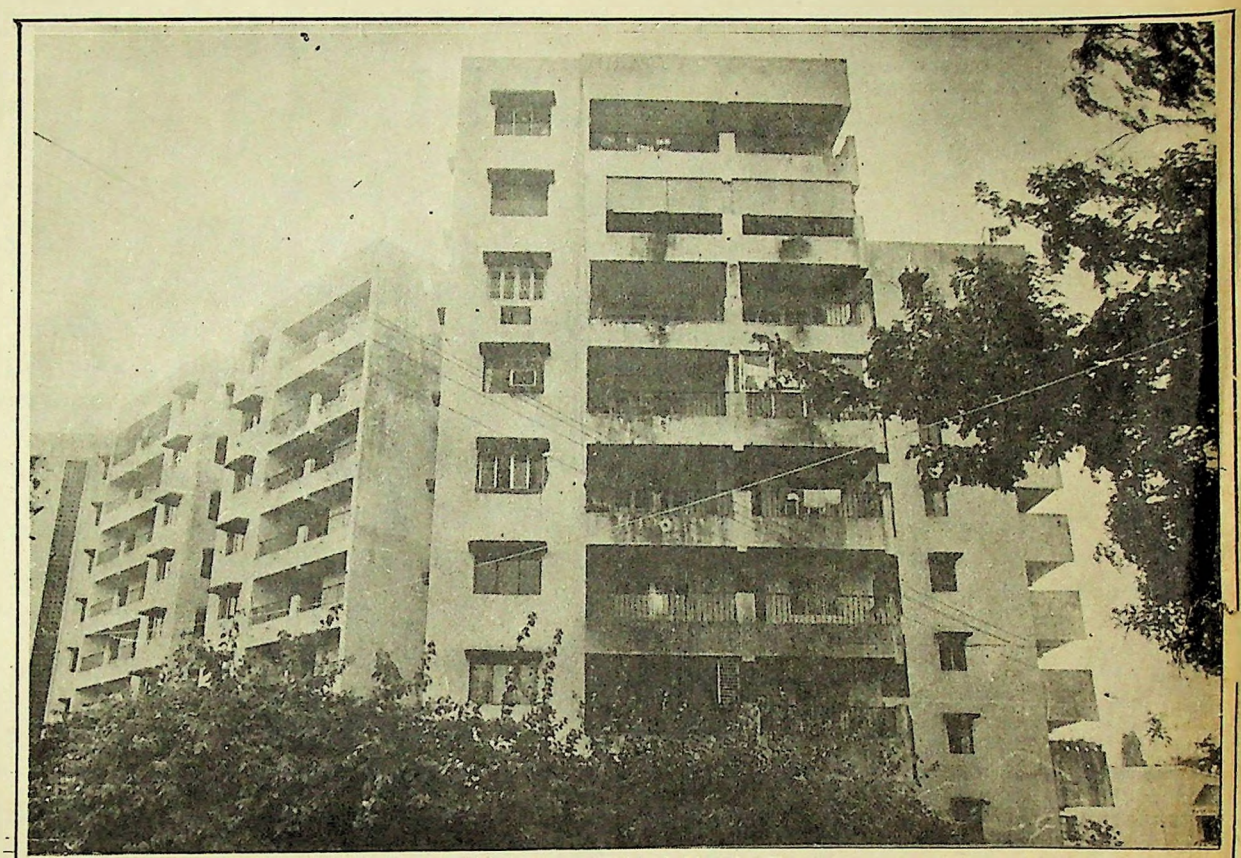
Ground space for parking is another ticklish issue with most apartments charging Rs 25,000 to Rs 40,000. But considering the explosive price of house sites, dismal public transport system and tortorous procedures involved in securing a BDA site, it seems high rise apartments are here to stay. Builders also feel the flat-culture is fast catching on in Bangalore.

With new builders coming up, the business is getting increasingly competitive. Their advertisements are published in several foreign newspapers.

But residents have often discovered that not all real estate developers are reliable. One agency promised three way entertainment channel, 24 hours water supply, elevator, generator and hygienic waste disposal, but residents found when they moved in that none of these facilities was available. It was only later after persistent demands that they were provided.

The way Bangalore has grown during the last two decades reveals divergence between the plan and ground reality. The Outline Development Plan prepared for a population of 1.9 million in 1976 remained in force up to 1984 when the population exceeded three million. This has led to un-planned growth of the City.

Thus planning has to be more broad based with a clear vision of the future role of Bangalore in the national, and international context.



Highrise monstrosities choking the City

...The old bungalow culture is one of the casualties of progress. The highrise culture that is taking over was given a premature start by the government itself when it put up some of the ugliest buildings in the City. Some of them are not only aesthetically offensive monstrosities but also pose a danger to the occupants.....

SOME COMMENTS AND SUGGESTIONS

(on draft outline of State of India's Health Report drawn up on 21 Aug 1987)

(Since we missed the actual meeting it is likely that some of the ideas explored below may have featured in the discussions and hence may be repetitive. Also we are not adequately aware of the follow up action since August 1987. It is again likely that some of these issues have already been considered as the process of evolving the report continues. However, in order to internalise ourselves into the process activity, we raise these issues as a starting point.)

* It is a good idea to explore the concept and components of health and health care as the starting point of the report. However, we would have to ensure that the 'social process' dimension of health is given adequate emphasis and the technical, technological and managerial do not overshadow it as is usually done in the West with their pre-occupation with the Drug-Doctor-Hospital model. The emerging Indian experience has much to contribute in establishing the much needed social process dimension and the report would be a good base for this.

* There is need to situate the State of Health in the context of the socio-economic political conditions prevailing in the country and the nature of the ongoing development process. Hence some underlying framework of analysis and philosophy of approach

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should be arrived at so that the chapters, sub-sections and box items can be more than just bits and pieces of information. In the State of Environment Report the 'Statement of Concern' and the two papers by Anil and Dunu did this effectively. We need some such effort for this report not necessarily in the same way.

* An exploration of the known indicators of health like IMR, Life expectancy, MMR and Under-5 mortality etc., should feature in one of the first chapters and a critical view of the broad trends since independence. In spite of their limitations and the inadequate data bases, these do give some idea of the State of health of our population and offer a possibility of comparison with other countries. With some creative communications, these statistics and comparisons could bring out the stark realities and inadequacies of our situation--even some of the inequalities for that matter.

* Section II A. While obesity is a growing problem it is limited to a small number in a particular strata and should not get over emphasised.

* Section II A3 & A4 Of particular interest to us. Send further details of the evolving format.

* Section II A5. SCs, landless labourers and urban slum residents are equally vulnerable groups and their nutritional status could be explored in item iii) other disadvantaged groups.

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* Section II A6. Lathyrism is an unusual and unique case study but the problems of anemia, Vitamin A deficiency and endemic goitre are of far greater epidemiological significance. NIN has done pioneering work on Vitamin A resulting in the world's largest 6 monthly distribution programme and this needs definite comment.

* Section II A7. The relevance of nutrition rehabilitation centres are in question. Therefore, is it a worthwhile case study? The focus on the other hand could be a wide range of projects using locally prepared nutritional supplements not necessarily in the NRC type set up but more community oriented.

* Section II A8. Food toxins particularly mycotoxins are a major problem and could be featured in a box item.

* Section III Could the changing agricultural environment be introduced as a separate chapter or subsection? The range of health problems attributed to agricultural maldevelopment are more than nutritional problems and pesticides: spread of malaria, Japanese encephalitis, problems related to large dams, marginalisation of rural poor and consequent changes in their health and nutrition, changing work patterns of women agricultural workers and its effects and so on. Would you want a draft outline with further details?

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While talking of environment and pollution there is a tendency to concentrate on urban and factory environment because of the diversity of the problem but the changing agricultural environment, in sheer magnitude of the people at risk is a far greater problem.

* Section II A5. Mental Health could well feature as a separate section rather than be clubbed with social environment. While adverse environment does affect mental health, mental health is more than just that.

* Section V A2. Medical Education is an important area no doubt, and we need to refer to the curriculum changes, Kottayam experiment etc., but it would be better to call this section something broader to encompass nursing/pharmacy education as well as the wide range of para medical training including MPWs and CHWs.
There are lots of issues and inadequacies but also lots of NGO alternative initiatives.

*Section V A4. This section needs to explore and document the role of the large variety of issue raising groups which include groups like mfc/SHR; Co-ordinating agencies like VHAI/CHAI/CMAI and the increasing range of smaller and sometimes more localised health activist and action groups. Here again NGO roles can be critically explored.

While focussing on NGO projects it is important not to project role of NGOs as 'innovators of model projects' but part of a wider NGO response where project building is only one of a three-pronged response. The other two being 'innovative training' and 'issue raising'.

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* Section V A5. The sub-sections of Primary Health Care are questionable especially items iv) and v). These could feature in a separate section on Secondary/Tertiary Health Care. It is important to record and critically comment on the secondary/tertiary health care build up since Independence and the pre-occupation with curative, institution and high tech medical model approach to health services in India and the increasing privatization and corporate industry take over of recent years.

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* Some additional projects/initiatives/issues that could feature as box items somewhere in the report:

(a) LOCOST Baroda - Low cost rational therapeutics
(b) ARCH, Mangrol - Under 5 care to rehabilitation of tribals evicted by Narmada Dam.
(c) Traditional birth attendants - situation and training experience.
(d) Deenabandhu - Herbal medicine dimension.
(e) Lok Vidgyan Sanghatana, Maharashtra
(f) Arogya Dakshata Mandal, Pune
(g) Appropriate technology in health care.

* Some resource persons

i. Nutrition/Agriculture: Dr SG Srikantiah, ex-NIN
Vandana Shiva - agricultural policy
ii. Endemic goitre : CS Pandav (AIIMS New Delhi)
iii. Medical Research : FRCH team Amar Jesani etc/Padma Prakash

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iv) Drug Issues : Anant Phadke, Mira Shiva, Dinesh Abrol etc.

v) Traditional systems : Dhruv Mankad

vi) Anemia/malnutrition in women : Kamala Jayarao

There are many others but you probably have a much larger updated list by now. We could add to it when we get it or atleast suggest people for areas where no resource persons have still been identified.

* A good bibliography highlighting the large range of meaningful publications, reports and project reviews could be an additional feature of the report so that readers interested in further details could follow up.

* We could support the sections on Health Status, Nutrition and Agriculture, Health, & Agricultural Development, Medical Education, Pesticides, Role of voluntary organizations, non-formal health education, Appropriate technologies in health care and health research. You must have already identified resource persons for these sections. We could be in touch with them and or respond to initial drafts by them.

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GOVERNMENT OF KARNATAKA
DEPARTMENTS OF TECHNICAL EDUCATION AND MEDICAL EDUCATION

PROVISIONAL ADMISSION TO FIRST YEAR DEGREE COURSES IN PROFESSIONAL COLLEGES IN KARNATAKA (ENGINEERING, MEDICAL, DENTAL, PHARMACY AND NURSING COLLEGES) FOR THE ACADEMIC YEAR 1993-94.

DTE/65/CET/93 — **FIRST SELECTION LIST – PAYMENT SEATS** — **Date : 15th October 93**

Following is the list of provisionally selected candidates for admission to the First year of B.E. / B.Tech. / B.Arch. / MBBS / BDS / B.Pharma / Bachelor of Nursing Degree courses based on ranks obtained and the choices given by the candidates. The candidates selected for Engineering, Medical, Dental, Pharmacy and Nursing should report to the Director of Technical Education, Palace Road, Bangalore 560 001, for Engineering courses and to the Director of Medical Education, Ananda Rao Circle, Bangalore 560 009 for Medical, Dental, Pharmacy and Nursing courses on or before **21.10.1993.** The admissions will start from **18.10.1993 (Monday).** The candidates will be given admission letter for proceeding to the allotted college for joining the college.

The candidates selected should produce the **original certificates** along with two xerox copies of the following documents:
(Common to all courses);

a) PUC-2 or equivalent qualifying examination marks card.
b) Study certificates for having studied for at least 5 years in Karnataka between 1st Standard and PUC-2 or equivalent or certificates claiming exemptions under any of the sub-paras 6(a) to (h) of General Instructions in the application form (If you are claiming under seats reserved for Karnataka)
c) Physical fitness certificate by a Registered MBBS doctor in the prescribed form.
d) Three copies of latest passport size photographs of the candidates of size 35 mm x 45 mm.
e) Date of birth certificate or S.S.L.C. Mark card or any document as proof of Date of birth.

Candidates selected for more than one course like Engineering, Medical, Dental, Pharmacy & Nursing have to decide and get themselves admitted to **any one course.** Candidates admitted to a course will automatically lose their seat in other courses. If a candidate gets admitted to a course and later (in subsequent list) gets a seat in other course, he can forfeit his earlier seat and get admitted to the course allotted in subsequent list. For example: If a candidate gets an Engineering seat in the first list and gets admitted and subsequently he gets a medical seat, he can forfeit his engineering seat and join Medical seat or any other course. **Candidates will be admitted only on submission of original documents.** If a candidate wants to surrender a seat to join another professional course he must request the Principal in writing to cancel his admission and obtain original documents and can claim refund of fees. **Candidates who have been allotted seats, but have not reported to the Directorate will not be considered for allocation in subsequent lists.**

CATEGORY / GROUP RESERVATIONS NOT AVAILABLE UNDER PAYMENT SEATS.

CHANGE OF COLLEGE / COURSE - a) Candidates should get themseives admitted by paying the prescribed fees and if satisfied with the allotment of college / course, should write as "SATISFIED" followed by his signature in the computer register at the Directorate of Technical / Medical Education.

b) Candidates admitted, but desiring change of college / course should write as "DESIRE CHANGE" and sign in the computer register. Their cases for changes will be considered as per merit in the subsequent list. No separate application for change of college / course will be accepted.

c) Candidates who are "SATISFIED" with the allotment as well as candidates who "DESIRE CHANGE" should pay full fees as given below.

d) The candidates are advised to preserve the fee receipt issued at the Directorate at the time of admission as it will be insisted upon at the time of joining another college, if change is given.

CHANGE FROM "PAYMENT SEAT" CATEGORY TO "FREE SEAT" CATEGORY AND VICE VERSA;

a) Candidate who joins under "Payment Seat" category and in subsequent lists gets a seat under "Free Seat" category, may cancel his "Payment Seat" and obtain the original documents from the Directorate by cancelling his seat under "Payment Seat" category and get admitted under "Free Seat" category.

b) Similarly a candidate who has joined a college under "Free Seat" category and if he is allotted a seat under "Payment Seat" category in this list or subequent lists, may cancel his seat under "Free Seat" category and obtain the original documents from the college and get admitted under "Payment Seat" category.

c) Candidate cancelling seats either in "Payment Seat" or "Free Seat" category is eligible to claim refund of fee for the cancelled seat.

FEES FOR PAYMENT SEATS - PRIVATE COLLEGES

COLLEGES	TUTION & DEV. FEES (Rupees per Annum)	OTHER FEES	NRI / FOREIGN STUDENTS (For full course)
ENGINEERING	25,000	1590	$ 20,000
MEDICAL			
Category 'A'	1,40,000		
" 'B'	1,20,000	1350	$ 50,000
" 'C'	1,00,000		
DENTAL			
Category 'A'	1,00,000	1350	$ 30,000
" 'B'	90,000		
PHARMACY	20,000	1350	$ 10,000
NURSING	15,000	1350	$ 5,000

1. Candidates joining private Medical and Dental Colleges have to pay Rs. 1000 and Private Pharmacy and Nursing Colleges Rs. 500 as University Fees to the concerned Universities.
2. Candidates joining Medical, Dental, Pharmacy and Nursing colleges have to deposit Rs. 1000 as Caution Money, which is refundable.
3. **NO NEED TO FURNISH BANK GUARANTEE**
4. Candidates should pay one year fees by Bank Draft (Nationalised Bank) payable at Bangalore in favour of Director of Technical Education / Director of Medical Education.

FOLLOWING ARE CUT-OFF RANKS UPTO WHICH SEATS HAVE BEEN ALLOTTED

CATEGORY	ENGINEERING	MEDICAL	DENTAL	PHARMACY	NURSING
KARNATAKA	7939	1958	2263	4192	1840
OTHER STATES (Including Karnataka)	5148	1121	1290	2399	1120

LIST OF PRIVATE PROFESSIONAL COLLEGES IN KARNATAKA WITH THEIR COMPUTER CODES

CODE	NAME OF COLLEGE	PLACE
	PRIVATE AIDED ENGINEERING COLLEGES	
21	BMS Engineering College	Bangalore
22	Basaveswara Engg. College	Bagalkot
23	PDA Engineering College	Gulbarga
24	Mainad Engineering College	Hassan
25	BVB Engineering College of Engg. & Tech.	Hubli
26	PES Engineering College	Mandya
27	SJC Engineering College	Mysore
28	National Institute of Engineering	Mysore
29	Dr. Ambedkar Inst. of Tech.	Bangalore
	PRIVATE UNAIDED ENGINEERING COLLEGES	
31	RV Engineering College	Bangalore
32	MSR Inst. of Technology	Bangalore
33	Dayanandasagar Engg. College	Bangalore
34	Bangalore Inst. of Tech.	Bangalore
36	Sir MV Inst. of Tech. Hunasamaranhally	Bangalore
37	KLE Engineering College	Belgaum
38	KLS Gogte Inst. of Technology	Belgaum
39	Vijayanagar Engg. College	Bellary
40	Rural Engineering College	Bhalki
41	BLDES Engineering College	Bijapur
42	SJC Institute of Technology	Chickballapur
43	Adichunchangiri Inst. of Tech.	Chickamagalur
44	SJM Institute of Technology	Chitradurga
45	Bapuji Inst. of Engg. & Tech.	Davangere
46	RTE Engineering College	Hulkoti
47	GV Trust Engineering College	KGF
48	NMAM IT Engineering College	Nitte
49	S.L.N. Engineering College	Raichur
50	STJ Engineering College	Ranebennur
51	JNN Engineering College	Shimoga
52	KVG Engg. College	Sullia
53	Kalpatharu Inst. of Tech.	Tiptur
54	Siddaganga Inst. of Tech.	Tumkur
55	Sri Sidhartha Inst. of Tech.	Tumkur
56	PES Institute of Technology	Bangalore
57	Malik Sandal Institute of Architecture	Bijapur
60	M.V.J. College of Engineering	Bangalore
61	Ghousia College of Engineering	Ramnagar
62	Islamiah Institute of Technology	Bangalore
63	S.D.M. College of Engineering & Technology	Dharwad
64	Guru Nanak Dev Engineering College	Bidar
65	Khaja Banda Nawas College of Engineering	Gulbarga
66	Manipal Institute of Technology	Manipal
67	Anjuman Engineering College	Bhatkal

COURSE CODE FOR ENGINEERING

Code	SUBJECT	Code	SUBJECT
A	Architecture	N	Textiles
B	Automobile	O	Bio-Medical Engg.
C	Ceramic and Cement Tech	P	Transportation
D	Chemical	Q	Mining
E	Civil	R	Telecomm Engg.
F	Computer Science	S	Silk Technology
G	Electrical	T	Metallurgy
H	Electronics	V	Civil Environmental Engg.
J	Industrial Production	W	Information Technology
K	Instrumentation Technolgy	X	Polymer Technology
L	Mechanical	Y	Manufacturing Engg.
M	Medical Electronics	Z	Printing Technology

CODE	NAME OF COLLEGE	PLACE
	B. PHARMACY DEGREE COLLEGES	
02	Visveswarapuram Institute of Pharmaceutical Sciences	Bangalore
03	Al-Ameen College of Pharmacy	Bangalore
04	V.E.T. St. John's College of Pharmacy	Bangalore
05	P.E.S. College of Pharmacy	Bangalore
06	M.M.U. College of Pharmacy	Ramnagaram
07	Dr. H.L. Thimmegowda College of Pharmacy	Kengal
08	Dayanandasagar College of Pharmacy	Bangalore
09	C.N.K. Reddy Institute of Pharmacy	Bangalore
10	Sri Siddaganga College of Pharmacy	Tumkur
11	G.K.M. College of Pharmacy	Bangalore
12	Krupanidhi College of Pharmacy	Bangalore
13	K.L.E' Society's College of Pharmacy	Bangalore
14	Milind Institute of Pharmacy	Bangalore
15	Pawan College of Pharmacy	Bangalore
16	Vivekananda Institute of Pharmacy	Bangalore
17	The Oxford College of Pharmacy	Bangalore
18	Rural College of Pharmacy	Devanahalli
19	Noorie College of Pharmacy	K.G.F.
20	K.V. College of Pharmacy	Chikkaballapur
21	JSS College of Pharmacy	Mysore
22	SAC College of Pharmacy	Chennarayapatna
23	Refuh-ul-Muslameen Education Trust, Farooquia Institute of Pharmacy	Mysore
24	College of Pharmacy	Manipal
25	NCSM College of Pharmacy	Dheralakatte, M'lore-3
26	V.L. College of Pharmacy	Raichur
27	S.C.S. College of Pharmacy	Harappanahalli
28	T.V.M. College of Pharmacy	Bellary
29	H.K.E. Society's College of Pharmacy	Gulbarga
30	Luqman College of Pharmacy	Gulbarga
31	K.P. College of Pharmacy	Bidar
32	M.M.H. Goel Institute of Pharmacy	Bidar
33	H.S.M.A.K. Charitable Trust, Mohamadi College of Pharmacy	Gulbarga
34	Sri Veerabhadreshwar Education Society	Humanabad
35	N.E.T. College of Pharmacy	Raichur
36	K.L.E. Society's School of Pharmacy	Belgaum
37	K.L.E. Society's School of Pharmacy	Hubli
38	Marata Mandal's College of Pharmacy	Belgaum
39	Al. Fatah College of Pharmacy	Hubli
40	Basaveshwara School of Pharmacy	Bagalkot
41	BLDE Association School of Pharmacy	Bijapur
42	Sonia Education Trust	Dharwad
43	NES Institute of Pharmacy	Shimoga
44	SJMM College of Pharmacy	Chitradurga
45	Bapuji Education Society's BEA School of Pharmacy	Davangere
46	Bharathi Education College of Pharmacy	KM Doddi, Maddur
47	M. S. Ramaiah College of Pharmacy	Bangalore
	PRIVATE MEDICAL COLLEGES	
05	Dr. Ambedkar Medical College	Bangalore
06	Kempegowda Inst. of Medical Sciences	Bangalore
07	JN Medical College	Belgaum
08	Adichunchangiri Inst. of Medical Sciences	Bellur
09	Al Ameen Medical College	Bijapur
10	JJM Medical College	Davangere
11	MR Medical College	Gulbarga
12	Devaraj Urs Medical College	Kolar
13	Kasturba Medical College	Mangalore
14	J.S.S. Medical College	Mysore
15	Sidhartha Medical College	Tumkur
16	Kasturba Medical College	Manipal
17	M.S. Ramaiah Medical College	Bangalore
19	BLDEA Medical College	Bijapur
	DENTAL COLLEGES	
02	Dr. Ramabai Ambedkar Dental College	Bangalore
03	PM Nadagowda Mem. Dental College	Bagalkot
04	SJM Dental College	Chitradurga
05	SDM Dental College	Dharwad
06	HKE Dental College	Gulbarga
07	Somanath Dental College	Bidar
08	KMC Dental Wing	Mangalore
09	KMC Dental Wing	Manipal
10	AB Shetty Mem. Dental College	Mangalore
11	KVG Dental College	Sullia
12	Bapuji Dental College	Davangere
13	College of Dental Sciences	Davangere
14	JSS Dental College	Mysore
15	KLE Dental College	Belgaum
16	Hasanamba Dental College	Hassan
17	MGVP Dental College	Bangalore
18	Gokul Edn. Trust Dental College (M.S.Ramaiah)	Bangalore
19	SGR Edn. Trust Dental College	Bangalore
20	P.C. Dental College	Bangalore
21	Sambaram Charitable Trust Dental College	KGF
22	Vignam Inst. of Dental Sciences	Bangalore
23	Vokkaligara Sangha Dental College	Bangalore
24	Academy of Liberal Edn. Dental College	Raichur
25	Al-Ameen Dental College	Bijapur
26	Yenopoya Dental College	Mangalore
27	Rural Gulbarga Dental College	Gulbarga
28	HKS Trust Dental College	Gulbarga
29	SKDE Trust Dental College (Hunasemaranahalli)	Bangalore
30	Babu Jagajeevan Ram Dental College	Bangalore
31	R.V. Dental College	Bangalore
32	Oxford Dental College	Bangalore
33	Sri Sidhartha Dental College	Tumkur
34	Sharavathi Dental College	Shimoga
35	KLE Dental College	Bangalore
36	Rajareshwari Dental College	Bangalore
37	Amruth Edn. Cul. Society	Bangalore
38	Rifah-ul-Must. Edn. Dental Col.	Mysore
39	Maratha Mandals Dental College	Belgaum
40	Sevalal Dental College	Bangalore
41	NSVK Dental College	Bangalore
	NURSING COLLEGES	
02	College of Nursing, Father Muller's Hospital	Mangalore
04	College of Nursing, M.V. Shetty Memorial Hospital	Mangalore
05	College of Nursing, K.L.E. Society Hospital	Belgaum
06	College of Nursing, Bapuji Hospital	Davangere
07	College of Nursing, K.M.C. Hospital	Manipal
08	M.S. Ramaiah College of Nursing	Bangalore
09	College of Nursing, Hyderabad Karnataka Education Society	Gulbarga
10	College of Nursing, Nitte Education Trust	Mangalore
13	P.C. Dental and Nursing College Trust	Bangalore
14	Oxford Nursing College, J. P. Nagar	Bangalore

(Dr. M. V. Ramanna)
Director of Medical Education

(Prof. P. V. Bhandary)
Director of Technical Education

DISTRICTWISE OBSERVATION ON THE MMR OF ICDS AS ON MARCH 93

Sl.No.	Name of the district	PHC reporting %	MO position %	MO trained %	LHVs position %	ANMs position %	SLM/PHC	AW visits by MO %	Severe malnutrition
1.	Bangalore (U)	68.42	96.72	69.49	96.15	98.46	2.38	29.57	0.30
2.	Bangalore (R)	82.35	95.65	70.45	95.24	91.07	1.35	19.77	1.09
3.	Chitradurga	82.05	82.17	82.17	85.96	96.96	1.81	19.52	0.57
4.	Kolar	90.74	90.32	66.07	84.51	91.71	1.36	13.65	0.66
5.	Shimoga	94.44	79.21	75.00	88.24	91.57	1.44	30.26	0.44
6.	Tumkur	100.00	83.21	89.47	88.06	93.33	1.74	84.59	0.52
1.	Bangalore DVN	88.73	85.94	76.95	88.71	93.83	1.61	21.56	0.57
7.	Belgaum	81.08	88.24	73.33	88.64	87.06	1.33	19.24	0.14
8.	Bijapur	85.71	88.57	66.13	77.78	90.77	1.41	23.19	0.97
9.	Dharwar	86.49	84.62	54.55	91.23	97.41	1.53	23.26	0.52
10.	U.Kannada	71.43	86.96	82.50	92.31	96.97	1.26	28.39	1.11
2.	Belgaum DVN	82.48	86.82	66.52	87.21	92.77	1.41	22.78	0.56
11.	Bellary	95.24	87.50	71.43	93.33	79.01	1.60	20.83	2.30
12.	Bidar	72.41	90.00	75.56	59.26	90.75	1.23	19.81	0.42
13.	Gulbarga	74.55	82.67	41.94	71.43	78.69	1.51	14.24	1.52
14.	Raichur	51.72	86.21	64.00	62.50	83.33	1.33	11.15	1.08
3.	Gulbarga DVN	72.39	86.19	61.33	72.95	82.20	1.44	16.08	1.40
15.	Chickmagalore	80.00	74.32	54.55	91.18	88.42	1.25	16.02	0.77
16.	D.Kannada	81.43	78.49	53.42	96.20	90.43	1.22	17.29	0.63
17.	Hassan	76.47	76.09	60.00	86.21	81.25	1.15	21.66	1.36
18.	Kodagu	75.00	82.14	52.17	94.44	79.05	1.58	15.74	0.43
19.	Mandya	85.71	91.38	83.02	94.44	90.05	1.37	21.73	0.32
20.	Mysore	70.77	94.07	54.95	93.65	86.32	1.32	16.22	0.35
4.	Mysore DVN	77.73	83.15	59.22	93.44	87.01	1.29	17.82	0.56

Surveys/Studies conducted by ICDS consultants.

1. Infant and early childhood mortality 1988-1991 at Channarayapatna, Hosadurga, Sullia, Bhadravathi and Ponnampet projects.
2. (i) Annual survey at Hunsur project-1990-91
   (ii) Status of adolscent girls at Hunsur project-1990-91.
3. Study on impact of ICDS on phycholorical development of children at Malavalli project-1991-92.
4. Annual survey at Nanjangud project 1992-93.
5. Annual survey at Siraguppa project 92-93.
6. Annual survey at Bellary urban project 93-94.
7. Baseline survey pilot project(Rural) T. Narasipura 1976.
8. First repeat survey - 1980.
9. Annual survey at Kollegal(Rural) project-1985.
10. Annual survey at Mysore(U) project - 1986.
11. Annual survey at Malur (Rural) project-1983-94.
12. Study of Infant and Early childhood Mortality in 3 Rural ICDS projects-T. Narasipura, Kollegal, Kanakapura-89-to 91.
13. Coverage Evaluation survey of Immunisation Nelamangala-1980.
14. Annual survey at Bangalore(U) project-1991.
15. Vit. 'A' prophylaxis survey at Bangalore(U) project-1992.
16. Annual survey at Devanahalli(Rural)project-1993.
17. Impact of ICDS on fertility regulations- study.
18. ICDS - an attempt at Primary Health Care through Multisectoral approach.
19. A study of A.W.W - regarding their role in ICDS.
20. A study of diarrhoeal disorders among 374 children in 7 anganwadi areas.
21. Acceptance of Oral Rehydration therapy - a follow up study.

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STATE LEVEL CONVENTION OF ICDS
19th JUNE 1993

AGENDA

10.00	A.M.	REGISTRATION	
10.30	A.M.	Inaugural Session	
		Welcome	Senior Adviser ICDS.
		Status of ICDS in Karnataka	Offg. C, Data Analysis, ICDS.
		Introductory Remarks	State Co-ordinator, ICDS.
		Inaugural Address	Secretary to Health & F.W. Services, Govt.of Karnataka.
		Address by Director of Women & Child Development.	Director of Women & Child Development.
		Address by Chairman Central Technical Committee	Dr.B.N.Tandon. Chairman, C.T.C. Delhi.
		Presidential Address	Secretary to Social Welfare Department, Govt.of Karnataka.
		Vote of Thanks	Senior consultant (ICDS) Karnataka.
11.15	A.M.	TEA	
11.30	A.M.	ICDS and its impact	Dr.B.N.Tandon, Chairman, CTC., New Delhi.
12.30	P.M.	Inter Sectoral Co-ordination in effective Implementation of ICDS.	Dr.Krishna Raju Joint Director, ICDS.
1.00	P.M.	Energy Food & Supplementary Nutrition Programme.	Mr.Balasubramanyam, Managing Director, Agrocorn products, Bangalore.
1.30	P.M.	LUNCH	
2.15	P.M.	Promotion of Children's Mental Health through ICDS Need & Scope.	Dr.Channabasavanna, Director NIMHANS, Bangalore.
2.45	P.M.	Implementation of ICDS Achievements/Suggestions	Chief District Adviser Asst.Director(W&C.D) consultant, ICDS.
3.15	P.M.	Group Discussions. Topics:-	
		i. Providing Nutrition Services to - 0.3Years effectively	
		ii. Strengthening the referral services.	
		iii. Training Monitoring and feed back system.	
4.30	P.M.	Concluding Session	Presentation of Reports
			a) Concluding Remarks from state Co-ordinator.
			b) Director of Women & Child Development.
		Vote of Thanks.	

COMMUNITY HEALTH CELL

47/1 St Mark's Road
Bangalore 560001

22 March 1988

THE STATE OF INDIA'S HEALTH REPORT
(an initiative facilitated by VHAI, New Delhi)

Section: Education of the Health Team

A--A Statistical overview of the quantitative response in the 50's; 60's; 70's & 80's. (Pictorial presentation)

Trends and inadequacies
Manpower trends--comparisons

B--Medical Education

i. 150 years of Rhetoric/relevance
ii. The PSM Departments--enablers or blocks!
iii. Community oriented medical colleges--tinkering with reform
iv. The 'Shrivastava' Report--a serious indictment
v. The Kottayam and Jamnagar experiments - lost initiatives
vi. The 'ROME' programme - white elep hants let loose
vii. Capitation fee medical college - business in medical seats.
viii. An alternative curriculum - a non-starter
(responses of MCI, IAAME, mfc)

C--Nursing Education

i. Overview of 5 decades--inadequate investment and confusing classifications.
ii. A 'status' problem and a gender bias
iii. Community 'nursing' alternatives

D--Paramedical training

i. The unipurpose responses of the 50's & 60's.
ii. The multipurpose metamorphosis - Kartar Singh Committee & beyond.

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iii. The Gandhigram explorations
iv. Evolving the three tier system - workers, supervisors and assistants.

E-- The Community Health Worker

i. The NGO pioneers
ii. The CHW scheme and evaluation--euphoria and disillusionment
iii. The CHW - lackey or liberator--theNGO innovation continues
iv. The anganwadi worker - ICDS alternative
v. Alternative ped gogy - helping health workers learn : the Indian experience.

F--Education in Public Health

i. DPH to MD - loss of the old guards
ii. The story of three institutions: AIIPHH/AIIMS/NIHFW
iii. The community health alternative - masters/diplomas/leaders JNU/RUHSA/Deenabandhu
iv. Courses and more courses - the mushrooming NGO sector

G--Training of Dais

i. Recognising the traditional 'obstetrician'
ii. Training - from condescension to dialogue

H--Education in Mental Health

i. Reaching the unreached
Educational innovation to promote mental health skills in the 3-tier health system.

I--Training in the 'Traditional' sector

i. The non-allopathic training base - recognising the step brother
ii. Where are we heading in Ayurveda, Homeopathy, Unani, Siddha, Yoga and Naturopathy?

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iii. Separate streams or integration--a knotty problem in training.

J--Continuing Education of the Health Team

i. A non-starter programme
ii. Leaving the field for pharmaceuticals and multinationals.

K--Educating the Health Team - A final comment

a. Trends towards Health for All by 2000 AD: challenges/alternatives
b. Building on failures/inadequacies and micro level experiences
c. A plea for an alternative pedagogy & plan for manpower education.

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Resource persons for section apart from Community Health Cell Team, Bangalore

1. Dhruv Mankad and contributors to mfc medical education anthology
2. FRCH Bombay (Ravi Duggal)
3. Prof Banerji, JNU, CSMCH
4. Rani & Abhay Bang, Search, Gadchirol
5. Ulhas Jaju, MGIMS Sevagram
6. ARCH Team, Mangrol
7. Mohan Isaac & Joseph Panackel, NIMHANS
8. Abraham Joseph, CMC Vellore
9. Daleep Mukerji, CMAI (ex-RUHSA)
10. Prem and Hari John, ACHAN & ANITRA
11. Mira Shiva, Manjunath and VHAI Community Health team
12. CS Pandav, AIIMS
13. Dr CM Francis, Editor, Health Action
14. Prof George JosephCSI Healing Ministry, Madras
15. PK Karthiyaini (ex Rural Health Cell, GOI)
16. Community Health Team, CHAI, Hyderabad

All these persons will be informed about the outline of the section and requested to send their own papers on the subject or any other papers/reports/comments that they feel are relevant to the different sub-units of the section. Some of them will be requested to contribute some of the box items.
Four resource centres will be particularly tapped for background information--VHAI Documentation Centre, FRCH, JNU-CSMCH and mfc/CHC.

The section will be put together by Ravi Narayan and the rest of the Community Health Cell team in Bangalore.

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Health Systems & Services in Karnataka.

1.1. History & Evolution.

1.2. Govt. health sector →
No. of
(a) Hospitals (b) Sub-centres, PHCs, CHCs, HUs
(c) Tq & district level. (d) beds.
(d) personnel → doctors, nurses, dentists, pharmacists.
Paramedics etc. < General, Specialists.

1.3 Voluntary < health, gen.

1.4 Corporate & individual groups.

1.5 Rural, urban & tribal health status. slums

1.6 Blood banks / donors < Govt, Govt burns units, NGO.

1.7 Vital statistics inc. cause specific, age specific, sex specific. changing trends in morbidity.
District-wise — ?

1.8 National control / eradication programs related to Karnataka.
Women related & child related → ?

1.9 V yr plans. Expr on health.

1.10 Box items on —
(a) NIMHANS (b) Kidwai (c) Jayadeva
(d) NTI (e) Belgaum Health Instt.

1.11 PH labs, & Drugs related.

1.12 Agl. & Health 1.13 Panchayat raj & Health

1.14 Specific diseases / health problems. →
enteric fever, respiratory diseases, cardiac

burns.

& pulmonary Mbles, & Handicapped, leprosarium, STD, AIDS etc.

1.15 Immunisation, ~~→ &~~ CSSM → ?
1.16 people's perception → ein gen & underutilisation of H) services
1.167 Critical appraisal ⇒ ~~wherever applicable~~.
& ein. of & recommendations.

1.18. Bibliography.

leave out:

Printed pages → 40-45.
ie., 4 typed pages = 1 printed page
1½ spacing for typed material.
A4 page.

Health Systems & Services.

Govt.

1. History → esp. old Mys. } Dr. S.V. Ramarao IPA I
2. Current Status — Dr G.V. Nagaraj
   - Facilities
   - ~~Prog~~. Diseases
3. Specific State Progs
   - Indian SM & H
   - Allopathic
4. Regional disparities & Constraints
5. Structure of Planning & Implementation
6. Rural - Urban - Tribal differences.
7. Public health engineering

Voluntary.

1. Health & Devt Health groups → (VHAK, FEVOH)-K, CHAI, CMAI, KKM
2. Distribution, activities
3. Linkages to devt.
4. Issue based groups (DAF-K).

PRIVATE.

1. Hospitals / Nursing homes. (Nursing Home Assn) — Desai Nursing Home.
2. Diagnostic facilities Imp

A. Disease Patterns vs. Available facilities
B. Health Needs vs — " —
C. Vital Statistics → & emphasis on morbidity. NGO opinion.

Medical
Nursing
Pharmacy
Dental
Lab tech.
CHW etc.

HIS for those who implement.

Ch. 4. ISM → Directorate

Sources.

NTI
NIMHANS
PG Med. colleges
→ PG centres.
BMC, St Johns
Public & Mysore
Kidwai.
Minto
Venkateswara Eye Instt.
VV Hospital
ISEC
IISc – KCST
KRVP.
Newspapers & Periodicals.
Lokshikshana Parishad.
Jindal
Info centres.
Funding Agencies
AIIST.

Mysore.

MMC, AIISH, CFTRI, Ayurvedic College
ATI.

30/9/93 VHAK.

Qualitative
Quantitative

Health Services
Non-governmental organisations
Post-graduate studies in
Health Policy
Health systems
Health economics — governmental
other agencies
family.
Health Education

Journals
magazines
newspapers

Certain projects — successful; why were they successful
failure; why?
continuation
sustained — factors contributing

Emphasis on maternal care
child care

Allied sectors — water
Sanitation
agriculture

Desai nursing home.

Health State Plans
Budget — annual
Physical achievements — targets/achievement
strategies

nursing homes — government
Mallya

IIM — Shanmugam -
Bhatia -

Anand laboratories for diagnostic studies
Medinova -

Om consultants — Mr. Varadan
Mr. Mohan.

STATE OF HEALTH - KARNATAKA

VOLUNTARY AGENCIES IN HEALTH CARE:

Voluntarism in Health Care has been an old tradition in Karnataka, with many institutions over a century old. These institutions have become major hospitals, especially in the Missionary sector. Movements in social and economic development have also been quite active, with health as one of the areas of focus. Some efforts have developed into other areas from their entry point in health, understanding the links between Health and Development.

Voluntary efforts have arisen at each place in response to local needs. Hence, they have focussed on a range of issues like tribal health, physical handicap, training, school health, and so on. Their size, reach and approach to the problems they address, are as varied too. This is the essential strength of these voluntary agencies, who have been experimenting with innovative approaches, something the Government cannot do.

The voluntary agencies in the areas of Health and Development have joined hands in their work in federations like VHAK (Voluntary Health Association - Karnataka), CHAK (Catholic Hospital Association - Karnataka), CMAI (Christian Medical Association of India) and FEVORD-K (Federation of Voluntary Organisations for Rural Development in Karnataka). These federations interact with the Government on their behalf as well as help coordinate activities in the voluntary agency sector. Other agencies like the CHC (Community Health Cell) help in networking efforts in various areas of voluntary action.

Apart from these, Karnataka has a number of National Institutes, which play a national role, but are involved in local service and research.

What follows is a sampling of the varied areas of voluntary agency involvement, to given an idea of the needs of people and the varied ways they are being tackled.

-.-.-

NATIONAL INSTITUTE OF MENTAL HEALTH AND NEUROSCIENCES

The erstwhile 'Lunatic Asylum' later renamed as the 'Bangalore Mental Hospital' was unique in its services even before Independence. Consequent to Bhore Committee Recommendations, the All India Institute of Mental Health (AIIMH) was established in 1954, and based in the Mental Hospital premises. For administrative purposes the AIIMH and the Mental Hospital were amalgamated and thus in 1974, and the National Institute of Mental Health and Neurosciences (NIMHANS) was registered as a society.

NIMHANS is a multi-disciplinary organisation working simultaneously in:

* caring for those with mental disorders;

* training psychological, neurological, neurosurgical and nursing staff; and

* researching in several cognate fields.

Separate well-established departments in Clinical, Paraclinical, Diagnostic and Therapeutic areas undertake these functions. Research is done in Ayurveda too, a separate Epidemiology department is a unique feature, while the Library and Information centre is the referral centre for Mental Health and Neurosciences in India. The team approach is towards promotive, preventive and curative aspects of health. The Institute has been the core centre for developing a National Mental Health Programme and propogate and monitor its implementation in the country.

SPECIAL FEATURES

* The CLINICAL SECTION of NIMHANS cater to the needs of patients sufferring from psychiatric, neurological and neurosurgical disorders.

    + The out-patient department functions on all week days and offers a combined neuropsychiatric out-patient service too.

    + The in-patient ward has a total bed-strenght of 805, separate for children and adults.

    + A 24 hour neuro-psychiatric casualty and emergency service is available too.

*FACULTY: There are 15ule Questionnaire Schedule Questionnaire
Category Category Category Cate

Low income 77.1 74.8 61.6 62.

Middle income	25.7	20.7	35.4	28.
Upper income	6.0	3.8	9.8	8.
Rural	59.2	65.3	68.4	70.
Urban	8.5	10.1	13.9	15.
Tribal	23.5	23.5	12.6	14.
Forward caste	11.8	12.7	24.1	23.
Backward caste	35.2	43.1	33.5	39.
Scheduled caste	45.4	43.2	34.8	35.

INTERNATIONAL NURSING SERVICES ASSOCIATION (INSA/INDIA)

INSA / INDIA was started in 1982 aiming to train and enhance the skills of those working in Community Health to improve the quality of their programmes. They are health care professionals and others involved with socially and economically backward sections in rural and urban areas. Various voluntary organisations and state government bodies, as well as governments of Nepal, Bangaldesh and Mauritius have referred their staff for training at INSA.

The ten week Rural Health and Development Trainers Training Programme has six weeks of intensive class-room work and four weeks of field work covering a wide range of topics. The participants are helped to understand the comprehensiveness of health in its socio-cultural, physical, spiritual, economic and environmental aspects. Women's health and empowering them are focussed upon.

By the end of the 10th week, each participant draws up a one-year project plan to be implemented on their return. This is monitored by the well INSA / INDIA faculty through regular reports and field visits. At the end of the year a follow-up workshop in one of the developed projects helps in their learning to evaluate programmes using a participatory approach. At the end of the workshop they develop a long-term plan for 3 to 5 years.

From 1991, INSA / INDIA has also concentrated its efforts in the field of AIDS prevention education programmes in schools/colleges, youth clubs, industries and other groups in the city of Bangalore.

SOURCE : INSA / INDIA Report

NATIONAL INSTITUTE OF PUBLIC COOPERATION CHILD DEVELOPMENT (NIPCCD)

NIPCCD is an autonomous body working under the aegies of Ministry of Welfare, Deparmtment of Women and Child Development, Government of India, Bangalore, Guwahati and Lucknow are the three regional centres wherein they conduct research and training in the area of public cooperation and child development and is engaged in giving consultancy services in these areas.

The main objects of NIPCCD are:

1. To Develop and promote voluntary action in social development;

2. To take a comprehensive view of child development and develop and promote programmes in persurance of the national policy for children;

3. To develop measures for the co-ordination of governmental and voluntary actions in social development;

4. To evolve framework and perspective organizing children's programme through governmental and voluntary efforts.

The activities of NIPCCD are divided into various functions:

a) Public Cooperation Division
b) Child Development Division
c) Women's Development Division
d) Training Division
e) Monitoring and Evaluation
f) Common Serices Division
g) Resource Centre on Children

NIPCCD has come out with various publications and useful materials for workers/researchers/planners in various aspects of child development. Regular evaluation studies of the ICDS programmes are conducted by the regional centres.

NIPCCD has been awareded the Maurice Pate Memorial Award by UNICEF for its outstanding contribution in the field of child development.

SOURCE: NIPCCD Leaflet.

VIVEKANANDA GIRIJANA KALYANA KENDRA (VGKK)

Biligiri Rangana Betta (B.R.Hills) is the home of the 'Soliga' tribals who, with the changing times led a isolated existence for a long time. Declaring these areas as reserved forests and the introduction of new forest regulations in 1950's certainly helped to save the forests from the modern man, but made the Soligas discontinue some of their practices like shifting agriculture, hunting etc. This made them vulnerable and exploited.

It is to serve these brethren, that Vivekananda Girijana Kalyana Kendra was founded with the twin objectives of

a) improving socio-economic conditions of the tribal people and,
b) of helping them enrich their culture and values.

The centre is a non-sectarian humanitarian organisation, dedicated to the ideal of "service of God in Man". Orginally started in B.R.Hills, it has now spread to incorporated Yelandur, Chamarajanagar, and Kollegal taluks (including Male Mahadeswara Hills) and Satyamangala Taluk of Tamil Nadu. The project covers an area of about 60 kms radius and serves a tribal population of 20,000.

The essential aspect of the work has been to actualise the dream of a self-reliant, united and stable Soliga society by conducting various programmes each one aiming at unfolding the human potential, creating an awareness towards self-help and also to maintain the balance between modern day progress and the preservation of the Soliga's cultural identity.

HEALTH- Health care has been the main entry point of the Kendra and has established a ten bed hospital with an out-patient department, a laboratory, a dental unit and an X-ray unit. It also runs a Mobile Medical Unit catering to the needs of hamlets in the interior forests. An intensive Sickle Cell Anaemia Research and Screening Work has been undertaken as the disease is much prevalent among the tribals. Immunization, training, health education promotion of Traditional Medicine etc. are part of the Community Health activities. 'Karuna Trust', a Leprosy Eradication Programme has been launched at Yelandur taluk as it is hyperendemic for Leprosy. The Mother and Child Health Programme also runs a School Nutrition Programme. Two Mini Health Centres have been started to reach out to the larger population.

VOCATIONAL TRAINING AND COTTAGE INDUSTRIES- The cottage industry works on a co-operative principle wherein the actual working people become the members and run the industry. Vocational training is given in twelve cottage industries like Agarbatti, Cane and bamboo handicrafts, Bee-keeping, Coir-rope making etc.

COMMUNITY ORGANISATION- With the help of the Kendra's social workers, the tribals have organised themselves into 'Soliga Abhivriddhi Sanghas' in each of their 'Podu' (hamlet). These have grouped as 'Taluk Sanghas' and which in turn has a apex body coordinating called the "Soliga Abhivriddhi Mahasangha".

EDUCATION- VGKK runs a Non-formal school and Adult Education and Sunday schools at remote Podus, apart from the Primary and High Schools at the main centre. The schools aim at

* emphasizing an maintaining tribal identity,
* encouraging inherent skills to develop,
* inculcating spirit of community living and team work;
* vocational training to promote self-employment,
* emphasis on experimental learning,
* environmental education, and
* exposure to community organisation and social work.

The High School, first of its kind in Karnataka, caters to the needs of other tribal communities. A tribal hostel provides accommodation for nearly 200 boys and girls from interior hamlets.

OTHER ACTIVITIES: The Christians Children Fund, Bangalore has been helping foster-parents to sponsor tribal children, in the 'Family Helper Project' taken up by the Kendra.

With the assistance of ASTRA and KSCST (Karnataka State Council for Science and Technology), the Kendra has introduced appropriate technology to the tribal people like

* ASTRA Vole (smokeless fuel efficient chulhas),
* Solar Energy Appliances,
* Wind Mill,
* Gobar Gas Plant,
* Wood Gassifier,
* Cement soil block maker, etc.

The Kendra is also working in the following areas:

* Rehabilitation of Displaced Tribal Families,
* Agriculture, Dairy, Fisheries and Poultry,
* Low Cost Housing,
* Co-operative Societies, and
* Social Forestry.

SOURCE: New Frontiers of Tribal Development VGKK.

ST. JOHN's MEDICAL COLLEGE - DEPARTMENT OF COMMUNITY HEALTH

The Department of Community Health, St. John's Medical College as a voluntary organisation with social committments has focussed on the following areas:

1. Development of Health Training Programs for auxillary and lay personnel.
2. Coordination of training efforts with the Health needs of other voluntary organisations.
3. Enhanced collaborative research with private voluntary organizations and Governmental Health sector.
4. Development of Extension education capabilities by the Department.
5. Evolution of problem based learning methodologies for medical, paramedical and lay training.
6. Staff developments by way of exposure of varied training and research opportunities at all levels of trainee capabilities, thus emphasizing the place of "Health Team" approach in training.
7. Development of Urban training and research opportunities in anticipation of future health needs.
8. Opening up of existing frontiers in medical science research such as PRA techniques, qualitative research methodologies, plantation medicine specifics.

Three urban and nine rural health centres are being utilised for training service research activities. Training programmes are conducted for under-graduate and post-graduate medical students. Continuing Medical Education Programmes are held for Government Medical Officers, Practitioners of Indigeneous Systems of Medicine and Plantation Medical Officers in all areas of Community Health. Diploma as well as well Post-Diploma / B.Sc. students in Nursing form part of Community Health training. Training of Auxillary workers like Auganwadi, Traditional Birth Attendants, Community Health Workers, etc., is regularly undertaken.

Apart from these, health related training programs like Health Management, Food Hygiene, Teahcers Training, training for Deacons and Seminarians, Occupational Health, First Aid, etc., are being carried out. The Department also undertakes evaluatory and research projects.

Some of the other unique projects are:

- the establishment of a Rural Health Training Centre at Mugulur village;
- Mahila Vikas Project; and
- Central Documentation and Monitoring.

MYRADA PLAN - H.D. KOTE PROJECT

The primary aim of the H.D. Kote project was to establish a micro level primary health care development system, managed and sustained by the community at the village level. The project has been concentrating in the health sector since its inception in early 1980's. Their activities can be broadly classified into:

1) Preventive Health Care.

2) Curative Health Care.

3) Development of Individual and Community Health Infrastructure.

The Preventive Health Care Programme concentrates on:

- training village birth attendants (dais),
- identifying village health promoters and anganwadi workers,
- initiating a health fund by starting self-help credit groups
- immunization,
- nutrition programs,
- family planning, and
- health education.

The project is attending to the curative aspects in health care by

- bearing the expenses of hospitalisation of the poor,
- training for the blind,
- rehabilitation services for the handicapped, and
- conducting various health camps.

Some of the health infrastructure development programmes at the individual level are in the nature of:

- providing housing for the homeless,
- electrification of houses,
- low cost latrines, and
- astra ole and biogas programs.

Some of the Community Health infrastructure development programs of the project are

- potable water system to ensure safe drinking water facility to the community,
- support to Government Primary Health Centres/Units, and
- Drainage with Community participation.

SOURCE: Report on Health Activities undertaken in H.D. Kote Project (1992).

PRARAMBHA

Prarambha is a Trust founded in 1985 by a group of people actively involved in rural development as administrators, trainers, active field workers, etc.

The concept is intended to:

- sponsor individuals to work for rural development
- help individuals to set up action groups in villages
- create support base for individuals engaged in rural development
- provide assistance to young groups already involved in development work
- provide administrative, financial groups, and other infrastructure needed by individuals / groups willing to work in rural areas
- serve as 'resource organisation' for persons / groups associated with rural development.

Prarambha has initiated a study on rehabilitation of irrigation tanks in Karnataka with the objective of drawing up an action plan and optimization of available water resource utilisation.

Prarambha's main commitments for the future are -

- to initiate 100 small development groups in the village of five drought prone districts of North Karnataka
- to create strong and committed team in each of the sponsored village and an information and training base in each district.
- to produce measurable and qualitative results in the villages like education, health care, savings, etc.

SOURCE: PRARAMBHA

ASHIKA

Ashika was started in 1987 to play the role of a catalytic agent in bringing out people's awareness and people's action for rural development through people's education. Ashika laid down specific objectives for women, youth, children and the weaker sections of the society.

For Women: To promote Sanghatanas among rural women and self employment activities through paper training and education.

For Youth: To foster among youth a spirit of geunine civic interest, social commitment and service to their community by conducting leadership training camps.

On the whole, the main activities of Ashika are Literacy, Self-employment, Vocational guidance, Environment education and Health with the help of low cost media like Street plays, charts, as well as group discussions and symposiums.

ASHRAYA

Ashraya is a shelter for the under-privileged children, which began its Welfare activities in 1972. Now it is a multi-faceted child welfare organisation, caring for destitute children in the age of 0-10 years. For the children awaiting adoption, a pre-school informal training is given. Ashraya encourages Indian as well as international adoptions, especially of physically handicapped and disabled children. The centre runs a Parent Support Group and takes care of necessary legal aspects before giving in a child to the new parents. Inter-country adoptions are conducted on the guidelines formulated by the UN, and on the basis of Supremen Court judgements.

Adoption counselling by a professional adoption counsellor include pre and post placement advice. Causes and classes are conducted for those who wish to adopt. Access is made available on reading materials, audio-visual aids, etc.

Apart from adoption, Ashraya also has mobile reaches for children of construction workers. They also run a day-care for children of working mothers.

Ashraya is helping to standardise adoption procedures in Karnataka, thus acting as a Pressure Group to prevent malpractises in any area of adoption.

SOURCE: ASHRAYA leaflet.

MADHYAM COMMUNICATIONS

Madhyam is a non-profit media organisation setup in 1983. Its primary objectives are:

- to fulfill the communication needs of the many groups and non-governmental organisations engaged in social action.
- to create public awareness of problems and issues like the oppression of women, tribals, caste and class injustice and consumer exploitation.

Madhyam's work comprises of training and support of cultural action groups. It is involved in production of communication materials and interaction with / consieutisation of mainstream media practitioners, journalists, film makers and other communicators. In all its work, Madhyam aims at preservation of cultural forms, encouraging tribal and folk art forms and their use for cultural action.

Madhyam's productions include communication materials on varied topics like tribal welfare, female child labour, trends in education, etc. Also they conduct training programs on folk arts, street theatre workshop, use and preparation of flash cards. Madhyam has setup a audio-visual resource centre at Bangalore to enable groups and grassroot organisations to have easy access to relevant films and audio-visuals.

SOURCE: MADHYAM leaflet.

THE ASSOCIATION OF THE PHYSICALLY HANDICAPPED (APH)

APH embarked on a mission in 1960 to educate, train and rehabilitate the orthopaedically handicapped. On an experiment basis, industrial jobs were acquired for the handicapped and this later became a hit as industries participated in the growth of APH. Rehabilitation through placements consumed lot of energy of APH and thus a Rehabilitation Centre was started in 1970 with foreign funds for acquiring machinery and other necessary tools.

The 'Shradhanjali' Integrated School is a innovative project of APH to provide medical and educational facilities for the children.

The Industrial Training Institute for Orthopaedically Handicapped was reorganised in 1975 along the lives prescribed by National Council of Training in Vocational Trades. The trainees receive a monthly stipend and need to appear for an examination before getting their placements.

Home-bound programs have been started for the severely handicapped who are either averaged or under-qualified to undergo formal training. Apart from these, an on-the-job training is also given with the State Governments assistance.

Source: APH Souvenir.

MADHYAM COMMUNICATIONS

Madhyam is a non-profit media organisation ~~with a commitment~~ set up in 1983. Its primary objectives are;

- To fulfill the communication needs of the mass groups and non-governmental organisations ~~in the country~~ engaged in social action.
- To create public awareness of problems and issues like the oppression of women, tribals, caste and class injustice and consumer exploitation.

Madhyam's work comprises of training and support of cultural action groups and those working with underprivileged groups. It is involved in production of communication materials and interaction with/~~on~~ conscientisation of mainstream media practitioners, journalists, film makers and other communicators. In all its work, Madhyam ~~works~~ aims at preservation of cultural forms, encouraging tribal and folk art forms and their use for cultural action.

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Source: Madhyam's leaflet.

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Source: APH Souvenir.

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mobile creches for children of construction workers. They also run a day-care for children of working mothers.

Ashraya ~~acts as a pressure group~~ is helping to standardise adoption procedures in Karnataka, thus acting as a Pressure Group to prevent malpractises in any area of adoption.

Source: Ashraya leaflet.

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Source: Ashika leaflet.

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Apart from adoption, Ashraya also has

base in each district.
- to create partnership among small groups, organisations and committed people outside the rural areas with regards to financial support.
- to produce measurable and qualitative results in the villages like education, health care, savings etc

Source: PARAMBHA leaflet.

ASHIKA.

Ashika was started in 1987 to play the role of a catalytic agent in bringing out people's awareness and people's action for rural development through people's education. Ashika laid down specific objectives for women, youth, children and the weaker sections of the society.

For Women:
To promote Sanghatanas among rural women and self employment activities through proper training and education.

For Youth:
To foster among youth a spirit of genuine civic interest, social commitment and service to their community by conducting Leadership Training Camps.

On the whole, the main activities of Ashika are Literacy, Self-employment, vocational guidance,

PARAMBHA.

Prarambha is a Trust founded in 1985 by a group of people ~~activ~~ actively involved in rural development as administrators, trainers, active field workers etc. ~~engaged~~

The concept is intended to:

- sponsor individuals to work for rural development
- help individuals to set up action groups in villages
- create support base for individuals engaged in rural development.
- provide assistance to young groups already involved in development work
- provide administrative, financial & other infrastructure needed by individuals/groups willing to work in rural areas
- serve as 'resource organisation' for persons/groups associated with rural development.

Parambha has initiated a study on rehabilitation of irrigation tanks in Karnataka with the objective of drawing up an action plan for restoration and optimization of available water resource utilisation.

Parambha's main commitments for the future are —

- to initiate 100 small development groups in the village of five drought prone districts of North Karnataka
- to ~~create~~ partnership among ~~small groups, organisations~~ and
- to create ~~a~~ strong and committed team in each of the sponsored village and an information & training

- rehabilitation services for the handicapped, and
- conducting various health camps.

Some of the health infrastructure development programmes at the individual level are in the nature of :-
- providing housing for the homeless,
- Electrification of houses,
- Low cost latrines and
- Astia ole and Biogas program

Some of the community health infrastructure development programs of the project are -
- Potable water system to ensure safe drinking water facility to the comm, and
- Support to Government Primary Health Centres / Units
- Drainage with Community participation.

Source : Report on Health Activities Undertaken in H.D. Kolé Project (1992).

MYRADA / PLAN H.D. KOTE PROJECT.

The primary aim of the H.D. Kote project was to establish a micro level primary health care devpt system, managed and sustained by the community at the village level. The project ~~with its most important area~~ has been concentrating in the health sector since its inception in early 1980's. Their activities can be broadly classified into:

1) Preventive Health Care.
2) Curative Health Care.
3) Development of Individual and Community Health Infrastructure.

The Preventive Health Care Programme concentrates on:

- training village birth attendants (dais),
- identifying village health promoters & anganwadi workers,
- initiating a health fund by starting Self-Help Credit Groups,
- Immunization,
- Nutrition programs,
- Family Planning and
- Health Education.

The project is attending to the curative aspects in health care by —

- bearing the expenses of hospitalisation of the poor,
- training for the blind,

graduate and post-graduate medical students. Continuing Medical Education Programmes are held for Government Medical Officers, Practitioners of Indigenous Systems of Medicine and Plantation Medical officers in all areas of Community Health. Diploma as well as well Post Diploma / B.Sc students in Nursing ~~are being trained in~~ Community Health training.

Training of Auxiliary workers like Anganwadi, Traditional Birth Attendants, Community Health Workers etc is regularly undertaken.

Apart from these, health related training programs like Health Management, Food Hygiene, Teachers Training, training for Deacons & Seminarians, Occupational Health, First Aid, etc are being carried out. The Department ~~has~~ also undertakes evaluatory and research projects.

Some of the other unique projects are —

- the Establishment of a Rural Health Training Centre at Mugulur village,
- Mahila Vikas Project and,
- Central Documentation and Monitoring.

DEPARTMENT OF COMMUNITY HEALTH
St. John's Medical College

The Department of Community Health, St. John's Medical College as a voluntary organisation with social committments has focussed on the following areas:

1. Development of Health Training Programs for auxillary and lay personnel.
2. Coordination of training efforts with the Health needs of other voluntary organizations.
3. Enhanced collaborative research with private voluntary organizations and Governmental health sector.
4. Development of Extention education capabilities by the Department.
5. Evolution of problem based learning methodologies for medical, paramedical and lay training.
6. Staff development by way of exposure to varied training and research opportunities at all levels of trainee capabilities, thus emphasizing the place of "Health Team" approach in training.
7. Development of Urban training and research opportunities in anticipation of future Health needs.
8. Opening up of exciting frontiers in medical science research such as PRA techniques, qualitative research methodologies, plantation medicine specifics etc.

~~Nearly~~ Three urban and nine rural health centres are being utilised for training, service and research activities. Training progammes are conducted for under-

SEARCH

SEARCH is a secular, non-profit voluntary organisation which started its intervention with NGOs in 1984. Over the years there has been a gradual transformation from a Training Institute to a Strategic Organisation playing multiple roles today.

* It is committed to the promotion of marginalised groups such as Dalits, Tribals, Landless Agricultural Labour, Women and Children.

* It is a support institution working primarily with voluntary agencies with the two-fold objectives of Human Resource Development and mobilising people around development issues.

* It collaborates with NGOs in initiating, promoting and strengthening issue-based networks.

* It carries out policy reviews and plays advocacy roles.

* It works with a variety of partners; People's Organisations, Network Associations, Donor Agencies and Government Departmernts, besides Voluntary Agencies and Support Institutions.

* It makes use of Participatory Methodology in Research, Training, and Evaluation.

Their interventions are based on a geo-political perspective in all the three states namely Andhra, Karnataka and Tamil Nadu. Regional Trainers Training Course is conducted in regional languagesfor middle level staff from NGOs to strenghthen their potential in training and direct this towards organising and promoting a large number of marginalised people's organisations.

NATIONAL INSTITUTE OF PUBLIC COOPERATION AND CHILD DEVELOPMENT (NIPCCD)

→ NIPCCD is an autonomous body working under the aegis of Ministry of Welfare, Department of Women and Child Development, Government of India. It ~~conducts research with the head office at New Delhi~~, B'lore, Guwahati and Lucknow are the 3 regional centres wherein they conduct research and training in the area of public cooperation and child development and is engaged in giving consultancy services in these areas.

→ The main objects of NIPCCD are:

1. To develop and promote voluntary action in social development;
2. To take a comprehensive view of child development and develop and promote programme in pursuance of the national policy for children;
3. To develop measures for the co-ordination of government and voluntary actions in social development;
4. To evolve framework & perspective for organizing children's prog thro' governmental and voluntary efforts.

The activities of NIPCCD are divided into various functions:

+ Public Cooperation Division
+ Child Development Division.
+ Women's Development Division
+ Training Division.
+ Monitoring & Evaluation
+ Common Services Divis
+ Resource Centre on Child

ACTION AND DISABILITY AND DEVELOPMENT (ADD)- India

Action on Disability and Development (ADD)- India was established by a group of disabled people and their friends with the following aims:

To relieve poverty and sickness amongst disabled and handicapped persons throughout India,
To advance any other exclusively charitable purpose for the benefit of disabled and handicapped persons,
To assist any other person, body or organisation engaged or seeking to engage in similar activities,
To carry on any appropriate activity for raising funds for the above mentioned objects.

ADD-I helps disabled people to identify their own needs and the best ways of fulfilling them under the 'meeting-trees in the villages'. The most commonly identified needs are:

* better appropriate transport,
* orthopaedic support,
* education and training, and
* the right to earn a living.

ADD-I is committed to work with disabled people in villages, since 80 percent of the disabled population lives in villages, whereas all the facilities for education, training and employment for disabled people are concentrated in cities and big towns. The strategy ADD adopts is to work through the voluntary agencies working in villages to reach disabled people. This is to avoid duplication of infrastructure and adding on disability as a development issue and not as a welfare issue to the agenda of existing voluntary agencies. The second task is to enable the voluntary agencies to give visibility to disability and to change attitudes towards disabled people.

As a result 41 self-help groups of disabled people have been established with a total membership of about 600. These disabled people come from 158 villages of seven taluks in four districts. Attempts are being made to provide schooling for handicapped children, to obtain transport concessions, to get land for collective farming and a forum to deal with women's issues.

NIPCCD has come out with various publication and useful materials for workers in various aspects of child development. Regular evaluation studies of the ICDS programme are conducted by the regional centres. ~~They also~~

NIPCCD has been awarded the Maurice Pate Memorial Award by UNICEF for its outstanding contribution in the field of child development

VIVEKANANDA GIRIJANA KALYANA KENDRA (VGKK)

Biligiri Rangana Betta (B.R. Hills) is the home of the 'Soliga' tribals who, with the changing times led a isolated existence for a long time. Declaring these areas as reserved forests and the introduction of new forest regulations in 1950's certainly helped to save the forests from the modern man, but made the Soligas discontinue some of their practices like shifting ~~cultivation~~ agriculture, hunting etc. This made them vulnerable and exploited.

It is to serve these brethren, that Vivekanandha Girijana Kalyana Kendra was founded with the twin objectives of improving socio-economic conditions of the tribal people and
→ of helping them enrich their culture and values.

The centre is a non-sectarian humanitarian organisation, dedicated to the ideal of "service of God in Man". Originally started in B.R. Hills, it has now spread to 8 incorporate Yelandur, Chamarajanagar, and Kollegal taluks (including Male Mahadeswara Hills) and Satyamangala Taluk of Tamil Nadu. The project covers an area of about 60 kms radius and serves a tribal population of 20,000.

The essential aspect of the work has been to actualise the dream of a self-reliant, united and stable Soliga society by conducting various programmes each one aiming at unfolding the human potential, creating an awareness towards self-help and also to maintain the balance between modern day progress

P.T.O.

and the preservation of the Soliga's cultural identity

HEALTH - Health care has been the main entry point of the Kendra and has established a ~~te~~ ten bed hospital with an out-patient department, a laboratory, a dental unit and an x-ray unit. It also runs a Mobile Medical Unit catering to the needs of hamlets in the interior forests. An intensive Sickle Cell Anaemia Research and Screening Work has been undertaken as the disease is much prevalent among the tribals. Immunization, training, health education ~~etc~~ promotion of Traditional Medicine etc are part of the Community Health activities. 'Karuna Trust' a Leprosy Eradication Programme has been launched at Yelandur taluk as it is ~~has~~ hyperendemic for leprosy. The Mother and Child Health Programme also runs a School nutrition programme. Two Mini Health Centres have been ~~established~~ started to reach out to the larger population

VOCATIONAL TRAINING AND COTTAGE INDUSTRIES - The cottage industry works on a co-operative principle wherein the actual working people become the members and run the industry. Vocational training is given in diverse cottage industries like Agarbathi, Cane and bamboo Handicrafts, Bee-keeping, Coir-rope making etc.

2 . . .

COMMUNITY ORGANISATION – With the help of the Kendra's social workers, the tribals have organised themselves into 'Soliga Abhivruddhi Sanghas' in each of their 'Podu' (hamlet). These have grouped as 'Taluk Sanghas' and which in turn has a apex body coordinating called the "Soliga Abhivridhi Mahasangh

EDUCATION – VGKK runs a Non-formal school and Adult Education and Sunday schools at remote Podus, apart from the Primary and High Schools at the main centre. The schools aim at

- emphasizing on maintaining tribal identity,
- encouraging inherent skills to develop,
- inculcating spirit of community living and team work;
- vocational training to promote self-employment;
- emphasis on experiential learning,
- environmental education, and
- exposure to community organisation and social work

The High School, first of its kind in Karnataka caters to the needs of other tribal communities. A tribal hostel provides accomadation for nearly 200 boys and girls from interior hamlets

OTHER ACTIVITIES – The Christians Children Fund, Bangalore has been helping foster-parents to sponsor tribal children, in the 'Family Helper Project' taken up the Kendra.

PTO.

With the assistance of ASTRA and KSCST (Karnataka State Council for Science & Technology), the Kendra has introduced appropriate technology to the tribal people like.

+ ASTRA Vole (Smokeless fuel efficient chulhas),
+ Solar energy appliances.
+ Wind mill
+ Gobar gas plant
+ Wood gassifier
+ Cement soil block maker etc.

The Kendra is also working in the following areas:

-> Rehabilitation Of Displaced Tribal Families
-> Agriculture, Dairy, Fisheries And Poultry
-> Low Cost Housing
-> Co-operative Societies, and
-> Social Forestry.

Source: New Frontiers Of Tribal Development
VGKK.

INTERNATIONAL NURSING SERVICES ASSOCIATION (INSA/INDIA)

INSA / INDIA was started in 1982 aiming to train and enhance the skills of those working in Community Health to improve the quality of their programmes. They are health care professionals and others involved with socially and economically backward in rural and urban areas. Various voluntary organisations and state government bodies, as well as governments of Nepal, Bangaldesh and Mauritius have referred their people for training at INSA.

The ten week Rural Health and Development Trainers Training Programme has six weeks of intensive class-room work and four weeks of field work covering a wide range of topics. The participants are helped to understand the comprehensiveness of health in its socio-cultural, physical, spiritual, economic and environmental aspects. Women's health and empowering them are focussed upon.

By the end of the 10th week, each participant draws up a one-year project plan to be implemented on their return. This is monitored by the * well developed projects helps in their learning to evaluate programmes using a participatory approach. At the end of the workshop they develop a long-term plan for 3 to 5 years.

From 1991, INSA / INDIA has also concentrated its efforts in the field of AIDS prevention education programmes in schools/colleges, youth clubs, industries and other groups in the city of Bangalore.

SOURCE : INSA / INDIA Report

* INSA/INDIA faculty through regular reports and field visits. At the end of the year a follow-up workshop in one of the *

REFERENCES

1. De Souza A. and De Souza D. (eds). 1984: Psychiatry in India, publishers, Shri Rajesh c. Bhalani, Bhalani Book Depot, Bombay, pp.1, 14. 15. 16.

2. Goldman , Howard H. Review of General Psychiatry, 2nd edn., 1988, Appleton Lange, Prentice Hall International Inc., pp.8, 9, 10, 17, 369, 699.

3. Major, Ralph H.: History of Medicine, 1954, Charles C. Thomas Publisher, Springfield, Illinois, U.S.A., Vol.i & Ii, pp.206, 218, 388, 487, 502,506, 652, 728, 729, 928, 929, 1038, 1042.

4. Castiglioni A.: A History of Medicine, translated by E.B.Krumbhaar, 1941, published by Alfred A.Knopf, New York, pp.451,452, 633.

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b) Child Development Division
c) Women's Development Division
d) Training Division
e) Monitoring and Evaluation
f) Common Serices Division
g) Resource Centre on Children

NIPCCD has come out with various publications and useful materials for workers/researchers/planners in various aspects of child development. Regular evaluation studies of the ICDS programmes are conducted by the regional centres.

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Source : NIPCCD Leaflet

With the deeper understanding, over the centuries, of the processes involved in mental disturbances and their manifestations, the treatment of the mentally disturbed has undergone radical changes. In the modern climate of opinion, it is difficult to believe that in the past, lunatics were caged in isolated premises and exhibited as strange animals, ~~against the payment of a small fee~~ against the payment of a small fee. A case in point, Phillippe Pinel not only recommended humane treatment for the mentally ill, but even lived with them in order to understand their habits and personalities; as such he should be credited for originating the concept of investigating such individuals as a whole, taking into consideration their environmental and social influences. To quote - "The modern trend is to combine biologic, psychologic and social intervention in a tailored approach to a particular patient with a specific disorder."[2]

In India, Psychiatry as a separate subject was introduced into the medical curriculum in the 1930's. Since then, despite considerable progress in the treatment of the mentally ill, few significant contributions to psychiatry in general have been made. An exception is the development of the concept of family therapy. The development of Yoga as a mode of treatment is no doubt beneficial in some psychiatric conditions, but further study is required.

Modern treatment is available in the metropolises and in a few of the larger cities, and for various reasons, benefits only a few patients. The large rural population (nearly 80%) is obliged to seek treatment from local temple priests, astrologers, soothsayers and traditional healers, all of whom provide inexpensive and easily available treatment, which however has the disadvantages of being ineffective and, occasionally harmful.

SOHK

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BANGALORE ONIYAVARA SEVA COOTA-BOSCO

BOSCO began in June 1980 by a group of students from Kristu Jyothi College Bangalore, which grew into a full fledged project in 1984. ~~It draws inspiration from DON BOSCO, an educationist~~ It approaches the problem by-

1) supporting the child in his effort to grow and integrate into society and

2) building a meaningful social and political movement capable of challenging those situations that leave children abandoned on the streets.

By adopting a preventive and promotive system of education, it aims to create an environment free from the dehumanising factors prevalent on the streets. BOSCO has a ~~four~~ 3 tier PRESENCE-

STREET PRESENCE: The innovative BUDDIVANTHA follow up is a comprehensive educational project and support to children through activities like Counselling, Literacy classes, Home Placement, Tracing missing children, Medical Help, Advocacy and acting as guardians of children, and Orientation programmes, picnics, drug deaddiction camps etc.

SHELTER PRESENCE: City centres, Day-Night Shelters become the home of these children till they reach their homes or a place of permanent settlement.

INSTITUTIONAL PRESENCE: BOSCO basically adopts a non-institutional approach in working with the children, but directs those in need to different ~~institutions~~ institutions which are already in existence.

BOSCO has evolved a YOUTH FOR YOUTH programme initiated to enable the fortunate youth of the city to interact with the less privileged youth on the steet and to create an awareness towards an effective social change. The elderly and the experienced form a PATRON'S GROUP to support and encourage.

Source: BOSCO leaflet.

RAGPICKERS EDUCATION AND DEVELOPMENT SCHEME (REDS)

R.E.D.S. had evolved from the initiative of the Jesuit Priests at Ashivard, Bangalore, along with an active collaboration and direct involvement by the members of the Christian Workers Movement, during 1979. It took shape in the form of a full fledged project providing shelter, care, education, recreation and rehabilitation in August 1985. The project is sponsored by the Archdiocese of ~~project~~ Bangalore, under the auspicies of the Bangalore Multipurpose Social Service Society. The financial assistance for the building and administration are provided by the MISEREOR, Aachen, West Germany. The project cares for 70 children at both the centres and works with 1500 on the streets of Bangalore.

R.E.D.S. ~~aimsxat~~ has drawn out an action plan:

* Minimise economic exploitation
* Facilities for bathing and temporary shelter,
* Saving Schemes to promote the habit of thrift and self-reliance,
* Life oriented Education,
* Cultural and recreational facilities,
* Rehabilitation,
* Co-operative Society

R.E.D.S. offers facilities in the areas of shelter, ~~EDUCATION~~ Education, Vocational Training, Recreation, Counselling, Job Placement and has a host of activites on its side. They maintain street level contacts with children, conduct short term programmes, weekend camps, research and documentation activities and community education and participation.

SOURCE: R.E.D.S. leaflet

NATIONAL TUBERCULOSIS INSTITUTE

The National Tuberculosis Institute located at Bangalore, in Karnataka State was started in 1990 by the Government of India through the active assistance and technical support of the World Health Organisation(WHO) and UNICEF. The main purpose for which this Institute was established are:

a) To formulate and evolve a practicable, economically feasible and widely acceptable tuberculosis programme for the entire country

b) To train medical and para-medical workers to efficiently implement the programme in rural and urban areas, and

c) To undertake necessary research to give substance and support to the above two aims.

In addition, the Institute also monitors the District Tuberculosis Programmes in the country. The NTI developed a methodolgy for organising TB control services in the community. The district, being an administrative unit of the country, is taken as the basic unit of National Tuberculosis Control Programme. The aim is that there must be at least one Cente, the District TB Centre (DTC) in each district. Today, these centres form the core of the National TB Control Programme.

The District Tuberculosis Officer is in overall charge of the tuberculosis programme in the district. He is assisted by a team consisting of a laboratory technician, an X-ray technician, a treatment organizer and a statistical assistant. All are trained at National Tuberculosis Institute in the organization of District Tuberculosis Programme. The function of the District Tuberculosis Centre is to organize and supervise the case-finding and treatment activity in all the health institutions in both rural and urban areas. The staff of these health institutions are trained in sputum microscopy and to treat the patients diagnosed by them.

Source : NTI Silver Jubilee

STUDENT MOBILIZATION INITIATIVE FOR LEARNING THROUGH EXPOSURE

(in existence since 1986).

SMILE is an attempt to mobilise and motivate college students from various academic backgrounds to:

* deepen their awareness of themselves and of the society in which we live.
* experience the day to day struggle for survival of the rural and urban poor through an exposure to their living realities.
* learn from the efforts of NGOs, which, while working for and with the poor, are discovering new and alternate approaches to development.

SMILE also supports students who are willing to work with an NGO as an outcome of their experiences. If one is a student (s)he becomes a SMILE participant and some of them are selected for an exposure programme every year, on the basis of their interest, sensitivity and awareness, and will be given a week long orientation before the exposure.

SMILE is in touch with a number of NGOs and Action Groups working in various aspects of development work. Along with a staff member of SMILE the student stays with a 'poor' family for a period of 4 to 6 weeks. The emphasis during the first exposure is on learning from the experiences of the people and the prevailing situation. The second exposure would enable the participant to visit two or three other organisations and with the third exposure the student is helped to discover her/his aptitude to become a development worker/activist.

SMILE participants have initiated small programmes, conducted surveys, case studies, awareness campaigns, etc.

SOURCE: SMILE leaflet.

CAIM TREATMENT AND RECOVERY CENTRE

CAIM is an acronym for Chemical Addiction Information Monitoring.

The CAIM Treatment and Recovery Centre offers an intensive, ~~extensive~~ 12 steps centered service for the treatment of the disease of chemical dependency. The treatment methods include an in-patient programme of variable length of stay as indicated as well as out-patient services individualised to the patient's needs. Counsellors function with a team of Physicians, Psychiatrists, Clinical Psychologists, Qualified Social Workers to meet the medical and Psychosocial needs of the patient.

The treatment method has elements of both Western and Eastern philosophies in a therapeutic ambience. Extensive use of individual and group counselling, didactic educational sessions, exercises, yoga and meditation, games etc form part of the rehabilitation process. At CAIMS Family Threapy is an integral part of the trearment plan keeping in mind the Co-Dependency factors.

The CAIM programme is specifically focused and designed to restore the chemically dependent person and their family members to optimal health and functioning of Body, Mind, Emotions, Spirit (Values) and Relationships.

CAIM is also equipped with a dual-diagnosis wing to treat addicts with other psychiatric disorders. It maintains a open door policy and conducts numerous self-help group meetings. It offers a full-scale implementation of an Employee Assistance Programme at various business and industrial centres.

SOURCE: CAIM leaflet.

VIMOCHANA

Vimochana is a Women's Organisation that has been attempting to protect and defend the rights of women wherever and whenever they have been violated. Working in and around the city of Bangalore for the past 13 years, Vimochana has also been a space for women to come and voice their views on any issue that affects them-ranging from ecology, militarism, communalism, domestic violence to the basic violation of any human right.

Source : VIMOCHANA leaflet

STREELEKHA

Streelekha is a project of the Society for Informal Education And Development Studies, a registered non-governmental organization in Karnataka. Streelekha is in contact with several women's groups in India and grew out of the experiences of some of the women in the women's movement.

Having taken on the mainstream publishing world which had marginalised women's writings, in 1985, they have today managed to lay specific focus on feminist works(be it in the form of fictions, poetry or theoretical research), as well as offer books on ~~various~~ other ~~faculty~~ areas. They also invite social meovements in India and the Third World to place for display and sale their publications, studies and newletters in the bookshop. Streelekha also has a wide collection of books in ~~xxxxxxxxxx~~ Kannada and other local languages and undertake translation work too. Streelekha has also been a reference point for Vimochana, ~~xxxxxxx~~

Source : Streelekha leaflet

* ~~Vimochana~~ They reaches out to women in distress through informal counselling and legal support, apart from initiating campaigns and discussions on other related social, political and legal issues.

#. Source: NIMHANS at a Glance

NIMHANS

The previously known 'Lunatic Asylum' later renamed as the 'Bangalore Mental Hospital' was unique in its services even before independence. Consequent of the Bhore Comm't Recommendations, the All India Inst of Mental Health (AIIMH) was established in 1954, and was based in the Mental Hospital premises. For administrative purposes the AIIMH and the Mental Hospital were amalgamated and thus in 1974 the National Inst of Mental Health and Neurosciences (NIMHANS) was established, registered as a Society under the Societies Registration Act, 1960).

NIMHANS is a multi-disciplinary org working simultaneously in:

- caring for those with mental disorders;
- training psychological, neurological, neurosurgical and nursing staff; and
- researching in several cognate fields. ★

The team approach is towards the promotive, preventive and curative aspects of health. The Inst has been the core centre for developing a national Mental Health Prog and propagate and monitor its implementation in the country.

Special Features –

+ The CLINICAL SECTION of NIMHANS caters to the needs of patients suffering from psychiatric, neurological and neurosurgical disorders.

→ the out-patient dept functions on all week days and

offers a combined neuropsychiatric out-patient service too
→ The in-patient ward has a total bed-strength of 805, separate for children and adults.
-7 a 24 hour neuro-psychiatric casualty and emergency service is available too.
+ FACULTY - There are 150 faculty and more than 100 resident doctors, other residents and post-graduates in various fields of mental health and neuro-sciences, specialised nursing care with 215 nursing staff.
+ DEPARTMENTS - The various departments at NIMHANS provides unique and ~~very specialised~~ care and expertise in their specialisations.
• The Psychiatry Department has Adult and Child Psychiatry sections. Emergency ~~Psychiatric~~ services are made available round the clock. A multi-disciplinary approach is practised here. The Adult Psychiatric unit runs a De-addiction centre and the Child Psychiatry dept a Child Guidance Clinic as well as a Mental Retardation Clinic.
• The importance of involving the family in the therapeutic programme is appreciated by ~~the~~ providing accomadation for nearly 90 families under the Family Psychiatric Centre
• The Neuro-centre caters to the needs of patients with neurological and neurosurgical problems and treatment with drugs, surgical intervention and physiotherapy are offered to the patients.
• The Rehabilitation Centre aims at helping an individual re-learn old skills or develop new ones and function to

the best of his/her ability and potential.

+ Extension services in five rural Satellite Clinics (Kanatapu, Guzju, Ramibidanu, Madhugiri and Maddur) are held regularly. Follow-up of the cases are done periodically.

+ Consultancy services to institutions like Central Prison, Remand Home, Certified Schools, Industries, Half-Way Home etc are worth mentioning.

+ Trends of services offered over a decade are diagramatically shown. (3 graphs).

+ Other facilities made available for patients and their relatives are a Dharmashala, a Consumer's Co-operative Society, Drug Stores, Horticultural Society, a Bakery and a shop of the Agro Industries Corporation.

★ Separate well-established departments in Clinical, Paraclinical, Diagnostic and therapentic areas ~~are~~ undertake ~~these~~ above functions. Research is done in Ayurveda too, a separate Epidemiology deptt. is a unique feature, while the Library & Information centre is the ~~largest on Mental Health issues~~ referral centre for Mental health and Neurosciences in India.

PARIVAR SEVA SANSTHA.

Parivar Seva Sanstha (PSS), a non-profit, voluntary organisation, affiliated to Marie Stopes International, London, is in the field of family planning, health and child care since 1978. It aims at protecting women from unwanted pregnacies and the attendant risks of maternal morbidity, Among the various projects are:

1. 31 Comprehensive Static Clinics.
2. 2 Rural Mobile Clinics.
3. Family Planning in Industries
4. Contraceptive Social Marketing
5. Mahila Mandal Project
6. Anganwadi (FLE and Safe Motherhood Project)
7. Soap Opera.
8. Family Life Education Project (FLE).

FLE for Adolescents are meant to assist in:

+ planning for their future family life so that they can achieve their full potential.
+ acquiring knowledge in the areas of sexuality, planning for a family health and communication. etc.

The FLE projects are also conducted with the assistance of National Service Scheme (NSS), Bharat Scouts and Guides (BSG) and involving school teachers.

PSS provides ~~information~~ skill to NGO's working in the community in dissemination of information on family planning, sexuality, etc.

They also conduct a 9 mth certificate correspondence course in FLE. They ~~have~~ conduct a diversified and training programme the duration & methodology of which varies according to the target groups.

KIDWAI MEMORIAL INSTITUTE OF ONCOLOGY.

The Kidwai Memorial Institute of Oncology established in 1973 is the second largest Regional Centre for Cancer Research and Treatment in the country in terms of patients numbers, accomadation and staff. The Institute is an autonomous body and provides comprehensive cancer care to the cancer afflicted in the State of Karnataka and in the adjacent areas of neighbouring states. The Institute is also involved in the major campaign of cancer prevention through Mobile Cancer Education and Detection Programmes organised routinely and periodically in rural, semi-urban and urban areas by the Dept of Community Oncology.

The Institute being a referral cancer centre and in view of the facilities available, about 70% of the patients are referred by various medical institutions and private practitioners. Over 10,000 new cases registered annually and about 1.85 lakh follow-up patients visits are recorded each year. ~~30% of it~~ Annually over 5000 patients are being treated as inpatients and over 1500 cases are operated.

An Anti-Tobacco Cell was started recently with an objective to create an awareness of the harmful effects of tobacco usage through education, and wherever possible, study & evaluate the results of that education & further modify and apply the research results accordingly in diff+ comny settings & target gps

Apart from imparting highly specialised treatment facilities to patients in the hospital, the Institute has initiated and promoted action for the estb of Peripheral

Cancer Centres at diff districts of Karnataka, to start with, Gulbarga & Mandya. The Trust has also estbd the Dist. Cancer Control Programme Projects at Dharwad & Chickmagalur. (Add fresh statistics)

SAMAJ PARIVARTANA SAMUDAYA (SPS)

(Society for Social Transformation)

SPS is a voluntary org (estb in 1983) working mainly in Karnataka in close co-operation with other voluntary organisations, networks and movements in order to build people's movements on a broader scale and have larger collective impact on the government policies through people's power. SPS thinks in terms of movements and not in terms of projects; encouraging people to organise & consciously struggle for issues like environmental protection & the right to work.

~~has ventured the~~

+ SPS is involved in the fight against pollution of Tungabhadra where the ~~Birla's~~ Harihar Polyfibres have been letting out dangerous industrial wastes into the river disturbing the human as well as animal life. SPS facilitated the formation of 'Tungabhadra Parisara Samitis' in various villages.

+ In the year 1984, a joint sector company called Karnataka Pulpwood Limited (KPL) was formed by the Karnataka Govt in collaboration with Harihar Polyfibres (HPF) and were leased out 75,000 acres of forest land for 40 years at Re per yr for cultivation of eucalyptus for captive consumption by HPF which makes man-made fibre. This deprived about 5,00,000 villagers of their basic necessities and which led SPS in forming An Action Committee for Protection of Common Lands. After much persuasion, in 1991 the KPL decided to wind up - a rare success story of an envtl struggle.

+ SPS ~~through~~ held series of meetings ~~held~~ with FEVOED-K and CES and has has worked out details of People's Participation in the Management of Natural Resources

+ SPS with FEVORD-K and Centre for Ecological Sciences (CES) played a significant role in a new project of the Karnataka Forest Dept called "Western Ghats Forestry & Env. Project" funded by Overseas Devpt Agency (ODA). They were able to convince the funders that the project had no component of people's participation & later as a result of which the funding was halted
+ SPS has been instrumental in starting the Jan Vikas Andolan (JVA) to collaborate with other campaigns and struggles all over South India and aiming at sustainable development.

SPS conducts regular training programs for activists & rural people and NGOs working in similar fields. Apart from ~~the~~ ~~news~~ publishing ~~the~~ 'Jagruthani' in Kannada & English, SPS has ~~pa~~ brought out various books and video cassettes too.

KASTURBA MEDICAL COLLEGE AND HOSPITAL (K.M.C)

KMC is a conglomerate of professional colleges including a Medical College, Dental College, Pharmacy College and a College of Nursing, all situated on the same campus in the university town of Manipal.

KMC aims at —

* providing education in the contemporary practice of health
* assisting the student in the attainment of professional skills,
* teaching awareness of the health professionals' responsibility to patients, colleagues & the community,
* encouraging clinical practice & research in the indigenous systems of medicine.
* providing subsidized health care to the local community & participate in overall rural devpt, etc.
* The library at KMC is one of its kind with several thousand books & journals, audio & video tapes etc. The library offers Medline & other CD-ROM computerised services. ~~Also an~~.

Rural Outreach Health Services are conducted weekly / monthly in 15 towns & villages upto a distance of 80 kms free of cost. Those who need in-patient care are referred to the hosp, and are given "Green Cards" to enable free treatment.

A network of seven Rural Maternal And Child Welfare Clinics (RMCW) homes with a total capacity of 80 beds & manned by auxiliary nurse-midwives offers health care to mothers & children in the rural setting where they live. Community Health Workers

were identified & trained to provide MCH care. The Commy Health Worker is involved in health monitoring, education & promotion services. The Commy Medicine dept operates weekly general & speciality clinics at the RMCW homes. In addition to these, health care is extended to preschool children in 28 anganwadis & school children.

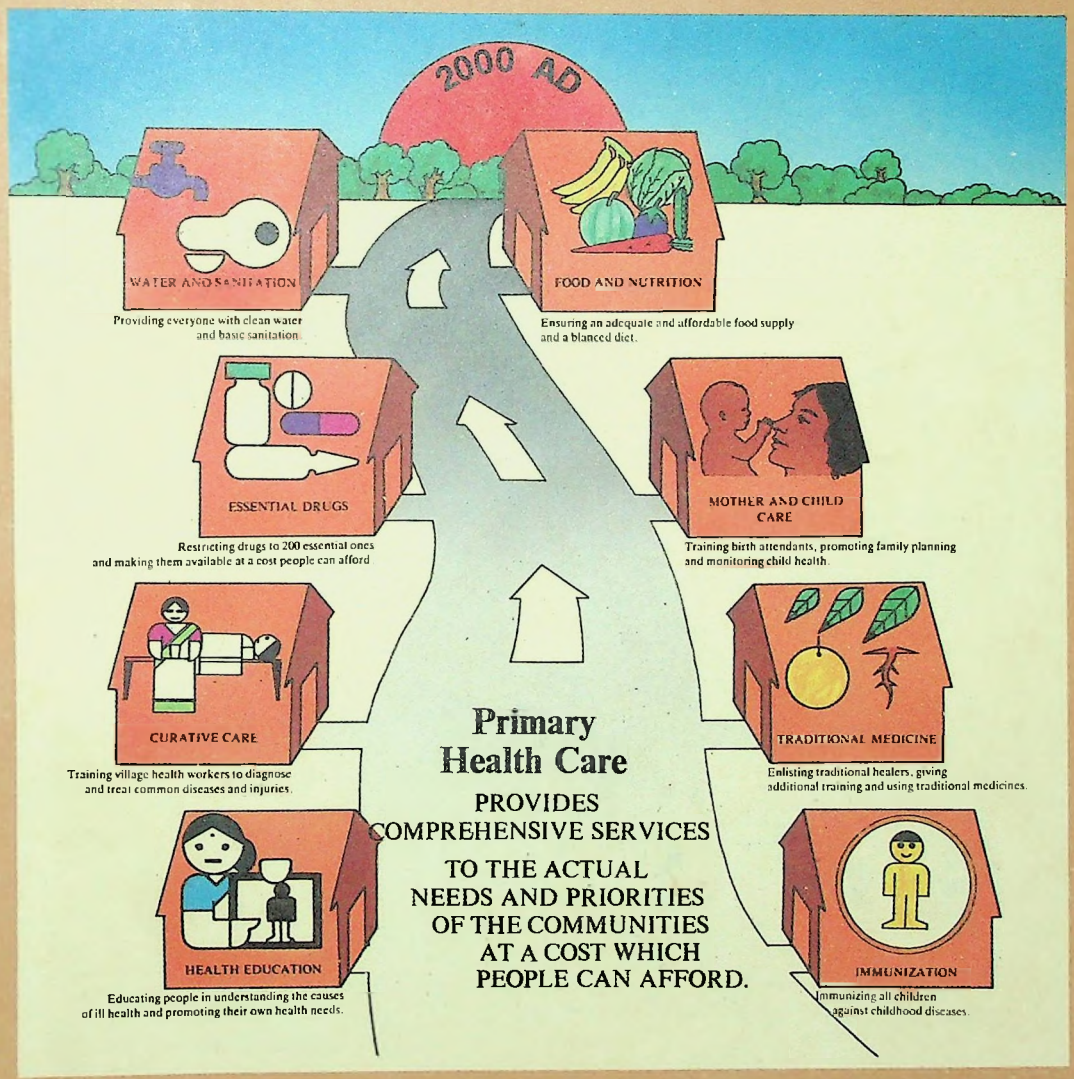
With the collaboration of Operation Eyesight Universal at KMC has been able to provide comprehensive eye care in the rural districts around Manipal.

With the assistance of International Medical Services for Health (INMED), KMC is creating & producing culturally appropriate health education materials.

With Ford Foundation aiding Kathahalli Health Project, one hundred Sanchalikas & village health workers have been trained to provide MCH. They also have a mobile & medical team with a social worker paying weekly or fortnightly visits to the interior rural areas.

Over the years, KMC has listed Commy Health Services in its primary commitments:

REPORT
ON
NATIONAL HEALTH POLICY WORKSHOP



VHAI

KARNATAKA VHA

The Need for Partnership

There is growing recognition that partnership between governments and non-governmental organizations is an inescapable necessity for the attainment of Health for All by the year 2000. It is also felt that the time is opportune for intensifying such partnership, based on mutual understanding identification of appropriate roles, complementarity of actions, mutual learning by doing and full fledged cooperation. The World Health Organization is promoting, fostering and strengthening such partnership.

HFA Leadership/IM 11

We acknowledge with thanks the financial support given to us by WHO through the Ministry of Health and Family Welfare.

Organized by :
KARNATAKA VHA
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WORKSHOP ON NATIONAL HEALTH POLICY

Dates : April 9 and 10, 1992
Venue : Institute for Social and Economic Change
Nagarbhavi P.O.
Bangalore - 560 072

ORGANISED BY:

VOLUNTARY HEALTH ASSOCIATION OF KARNATAKA,
VOLUNTARY HEALTH ASSOCIATION OF INDIA, AND
DIRECTORATE OF HEALTH AND FAMILY WELFARE SERVICES, KARNATAKA.

CONTENTS

PROLOGUE

Today we have a National Health Policy (1982). This comprehensive document is relevant to all involved in Health Care including the non-governmental sector. Among other things, **the statement of policy highlights the role of Voluntary agencies in Health and emphasises the Government's desire to involve, support and enhance this role.**

The very fact that we have a National Health Policy is an indication that there is **political will** towards better care of the people. There is need for careful study of this policy to determine.

(1) in what direction we are going, and
(2) how to operationalise this policy,

into improved practice than what it is today. Such a study will help people involved in planning Health Care at the State and District levels to orient their approach and decisions towards elements of the policy.

It is pertinent to recall and remember with gratitude initiatives by Voluntary Health Association of India (VHAI). When the Voluntary Health Association of India first printed the statement on National Health Policy, there were requests from individuals and institutions from all over the country for more copies of the policy. In some cases, bulk supplies were requested. This wide-spread interest inspired VHAI to plan a systematic dissemination and discussion on the policy. The first National Seminar on National Health Policy was held at New Delhi on April 23, 1983. State level seminars were to follow this.

Voluntary Health Association of Karnataka (VHAK) made a beginning towards this end, by initiating discussion on National Health Policy at St.Philomena's Hopsital, Bangalore, during 1984.

Following the workshop at St.Philomena's Hospital, during 1984, and in recognition of the crucial need to continue an active and constructive dialogue among all groups for continuing identification of progress or lack of progress in this regard, and to seek participatory measures to accelerate this process towards progress, a group of experts in the field of health both from Government and Voluntary Sector met at St.John's Medical College, Bangalore on October 31, 1991 under the auspices of VHAK. After an elaborate discussion it was felt that an intimate dialogue among the Directorate of Health and F.W.Services, District Health Officers, People's Representatives (Presidents of Zilla Parishaths and Chairmen, standing committee on Health of Zilla Parishads), Voluntary Organisations and Media persons along with experts in the field will help in the study of the Health Policy and to determine which way to go. This may ultimately pave the way to the formulation of a Health Policy suited to Karnataka with implementation at the District level.

The group of experts (who formed the working committee and the Resource) also felt that as an initial step, there is a need for creating awareness of the document itself among the participants. To meet this aspect, it was planned to invite papers on the document. The group, realising the impossibility of discussing the National Health Policy in its entirity within a span of 2 days, decided to focus the discussion on four specific issues:

(a) PRIMARY HEALTH CARE
(b) HEALTH EDUCATION
(c) INTER SECTORAL CO-ORDINATION
(d) HEALTH INFORMATION SYSTEM

In the pre-planning phase itself it was felt that it is imperative to promote a relationship of partnership between the Government and Voluntary Organisations. It was very strongly expressed that such an exercise will help promote District level planning.

PROGRAMME DETAILS:

9th ARPIL 1992

MORNING — **INAUGURAL FUNCTION**

1. Invocation	—	Mrs. Joyce Jayasheelan
2. Welcome	—	Dr.H.Sudarshan, Treasurer, VHAK
3. Lighting of the Lamp and Inaugural Address	—	Sri.T.R.Satish Chandran, Director ISEC and Former Chief Secretary Government of Karnataka
4. Key Note Address	—	Mr.V.S.Badari, Asstt. Director Population Centre, Bangalore.
5. Representing Government of Karnataka	—	Dr.T.Ranganatha Achar, Director Health & F.W. Services.
6. Representing VHAI	—	Dr.Mira Shiva, VHAI
7. Representing VHAK	—	Dr.Upendra Shenoy
8. Vote of thanks	—	Dr.Sona Kalyanpur Rao Hon.Secretary, VHAK

SCIENTIFIC SESSION : 9.4.1992 : 11 a.m.
Moderator : Dr.C.M.Francis, Director
St.Martha's Hospital, Bangalore-560 009.

PAPERS PRESENTED

'National Health Policy - an Overview'
Dr.(Mrs) M.K.Vasundhra
Prof. & HOD, Community Medicine
Bangalore Medical College, Bangalore.

"Current Health Status of India'
Dr. J.P.Gupta
Regional Director
Health & F.W.Services
Government of India

"National Health Policy - View point of Government'
Dr.C.R.Krishna Murthy
Addl. Director
Health & F.W.Services
Government of Karnataka

"National Health Policy - View point of Voluntary Agencies'
Dr.S.P.Tekur
Consultant Pediatrician
Community Health Cell
Bangalore.

"View of People's Representatives in National Health Policy'
Prof. M.V.Kulkarni and Dr.G.N.Prabhakar
Department of Preventive and Social Medicine
Mysore Medical College, Mysore.

(Paper circulated among the participants)

Clarifications : general response to presentations

9.4.1992 : **2.00 p.m.**

GROUP DISCUSSION

GROUP I	:	**'PRIMARY HEALTH CARE'**	**Facilitators** Dr.J.P.Gupta Dr.H.Sudarshan Dr.Mira Shiva Dr.S.Pruthvish Dr.Upendra Shenoy
GROUP II	:	**'HEALTH EDUCATION'**	**Facilitator** Dr.C.M.Francis
GROUP III	:	**'INTER SECTORAL CO-ORDINATION'**	**Facilitators** Sri. S.M.Subramanya Setty Dr.C.R.Krishna Murthy Mr.Mohammed Safiuddin
GROUP IV	:	**'HEALTH INFORMATION SYSTEM'**	**Facilitators** Dr.T.Annappa Rao Dr.S.P.Tekur

10.4.1992 : **9.00 a.m.**

Group Discussion (Continued)
Preparation and presentation of report within the group.

10.4.1992 2.00 p.m.

Plenary Session

Moderator	:	Dr.C.M.Francis
Presentation of reports of Groups I, II, III & IV		
Presentation of conclusions and Recommendations	:	Dr.S.Pruthvish
Valedictory Address	:	Sri G.Puttaswamy Gowda Hon'ble Minister for Health & Family Welfare Government of Karnataka
Remarks by	:	Dr.T.Ranganatha Achar Dr.C.R.Krishna Murthy Dr.C.M.Francis Participants
Vote of thanks	:	Dr. (Mrs) Sona Kalyanpur Rao Hon. Secretary, VHAK.

Formation of Committee to draft the proceedings.

INAUGURAL SESSION

The Workshop started with invocation by Mrs. Joyce Jayasheelan. Dr.H.Sudarshan, Treasurer, VHAK welcomed the guests.

Sri. T.R.Satish Chandra, Director, Institute for Social and Economic Change and Former Chief Secretary, Government of Karnataka, lighted the lamp and gave the inaugural address (given separately).

Sri. V.S.Badari, Assistant Director, Population Centre, Bangalore, delivered the Keynote address (given separately).

Dr. T.Ranganatha Achar, Director of Health and F.W.Services, Karnataka, spoke about the context of the workshop and its importance. The presence of all the senior officers of the Department of Health Services reflected the importance attached by the department to this workshop. It is necessary for Government and Voluntary Agencies to work together to achieve better health status of the people. The Government had considerable resources. Karnataka has made good progress in the health sector. But there were constraints. He promised all the help in improving the health of the people.

Dr. Mira Shiva, Public Policy Division, Voluntary Health Association of India, conveyed greetings from Sri Alok Mukhopadhyay, Executive Director, who could not be present. She pointed out specifically to the problem of irrational use of drugs. Unfortunately, Drug Policy is not part of the National Health Policy. Drug Policy is made by the Petroleum and Chemicals Ministry and not the Ministry of Health. Dr.Mira Shiva also referred to the possible impact of the New Economic Policy and privatisation of health care sector.

Dr.Upendra Shenoy, Member, Executive Committee of VHAK, appraised the participants, of the activities of Voluntary Health Association of Karnataka and the expectations of VHAK from this workshop.

Dr.Sona Kalyanpur Rao, Honorary Secretary of VHAK proposed the vote of thanks.

INAUGURAL ADDRESS

Sri. T.R. Satish Chandran

I am indebted to the Voluntary Health Association of Karnataka, together with the Voluntary Health Association of India and the Directorate of Health and Family Welfare, Government of Karnataka, for the unexpected privilege conferred upon me of being the Chief Guest at this function. It is ten years since the National Health Policy was enunciated and it is time that a review is made of the developments during the last ten years in order that future lines of advance can be identified. I compliment the Voluntary Health Association of Karnataka for organising this workshop which has brought together representatives of voluntary organisations and Government officials and other professionals interested in the area of public health.

2. If one were to ask whether the enunciation of the National Health Policy brought about any significant change in the strategy or content of health programmes in the country, I am afraid that one does not have much to report. In our country, we are good at framing policies; we have policy documents in diverse areas such as education, science, technology, etc. But, when it comes to translating the laudable sentiments and eminently reasonable recommendations contained in the documents into concrete action, we do not have a good record of performance. It is as though we are satisfied with the ritual of framing a policy and forget the substantive objectives immediately thereafter.

In the area of health also, whether at the National level or at the state level we do not see any innovative changes in the health strategy in the last ten years.

3. Undoubtedly, India has made good progress in the area of health since independence, progress being measured in terms of well-recognised parameters such as life expectancy at birth, infant mortality, etc. Clearly, the foundation had been laid long before the National Health Policy was enunciated. Substantial as the progress has been, we cannot claim that the health care situation in the country is satisfactory. There is still a vast difference between urban and rural, rich and poor in regard to access to health care. In the recent years, there is increasing recognition that it is not enough to achieve a reasonable rate of economic growth measured in terms of GDP or per capita income. It is felt more and more that 'development' is far more important than 'growth', since the former has many more dimensions than the latter. It is realised that for sustained long term advancement of the country, investment on human resources - mainly in elementary education and Primary Health Care - is vitally important. In the last two years, the United Nations Development Programme has brought out an annual Human Development Report. Taking into account various parameters such as per capita income, enrolment in Primary Schools, number of years of schooling, life expectancy at birth, infant mortality etc. a human development index has also been evolved. Unfortunately, India still figures pretty low among the list of countries because of its low *human development index*. It is clear that we have a long way to go before we can feel satisifed regarding the health status in the country.

4. Among the States in India, Karnataka has performed better than many other states in the area of health. The 1991 Census shows that the annual compound growth rate of population during the decade 1981-91 came down to 1.9 percent. This is certainly a matter of some satisfaction and it reflects the good work done by the health services in the State. Nevertheless, we should take note of the fact that the gap between Karnataka and other states is steadily narrowing down. Karnataka had a head-start because of the good network of health services developed in the old Mysore State, but in the recent years the proportion of Government expenditure on medical and health services has been lower than in many other States. One would not attempt any comparison with Kerala, but it is interesting that the share of health expenditure in Karnataka is lower than in Tamil Nadu for instance. The situation is aggravated by the distortion in the allocation of expenditure for preventive rural health care on one hand and for medical education and urban curative services on the other. The proportion of expenditure on the latter is disproportionately high. No doubt this tendency is visible in a few

*Director, Institute for Social and Economic Change, Bangalore-72 and Former Chief Secretary, Government of Karnataka.

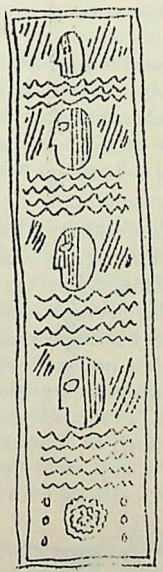
other States also, but this should not console us. Thus, viewed overall, **Karnataka's performance in the health sector shows weaknesses and deficiencies which need to be corrected urgently.**

5. The world over, it has been realised that a development programme oriented towards a community is more effectively implemented if there is participation of the community or of the beneficiaries. The concept of participatory development implies people's involvement at all stages - planning, implementation and evaluation. The participation can be through formal or informal components. Voluntary groups represent the informal components. In Karnataka, a major step was taken to set up formal structure at the district level and below entrusted with the responsibility for the planning and development of their respective areas. The *Zilla Parishads* and Mandal Panchayats were designed to be instruments of decentralisation which would also secure greater accountability in the implementation of development activities. Unfortunately, one sees in the recent months a tendency to weaken the structure if not to wholly dismantle it. It is sad that after having taken one step forward the State is taking two steps backward.

6. In the context of the difficult economic situation facing the country, major economic policy changes have been introduced in the recent months. This may have an indirect impact on the health sector. Given the general approach of curtailing governmental activity and relying more and more on market forces, there is a **strong possibility of expenditure on social services being reduced. This would be most undesirable as it would further reduce access of the poor to health services.**

7. One of the aspects of the new economic policy is abolition of subsidies. Subsidies are of two kinds - direct or open subsidies and covert or concealed subsidies. A recent study by the National Institute of Public Finance and Policy estimated the total amount of direct and indirect subsidies given by the Central and State Governments together at Rs.42,000 crores a year. The major part of it is accounted for by the State Governments. These comprise mainly indirect subsidies in the provision of social services, of which health is one. It is argued that government should recover a fair proportion of the cost it incurs in delivering its services. While one would not suggest charging the poor for the educational or health facilities provided to them, there is no reason why those who could afford to pay should not be required to meet reasonable charges. Today, we have a peculiar situation of higher education receiving a level of subsidy greater than primary education. There is a similar distortion in the area of health also. The approach should be to charge those who can afford, and use the additional revenue to improve the quality of service to the poorer sections of the community.

8. It is encouraging that a large number of voluntary agencies are working in the health area and many of them are represented here. I hope that during the discussions in the next two days, constructive ideas and suggestions will be generated which will help to shape the health policy in future.



FACTORS PROMOTING HEALTH STATUS*

V.S.BADARI, POPULATION CENTRE, BANGALORE.

Since Independence, India made considerable progress in the field of health. Smallpox has been eradicated. Cholera, Malaria, Tuberculosis and other communicable diseases have been controlled. A number of medical institutions have been established all over the country for providing curative services. A comprehensive health policy was formulated a decade ago. As a result of these measures, the death rate could be brought down to a reasonably low level of 10 per 1000 population. The expectation of life at birth has increased to nearly 60 years. Yet, there is lot more to be achieved, especially with regard to women and children. For instance, the infant mortality rate per 1000 live births is around 90, which is five times the rate in the developed countries. The maternal mortality rate is about 5 per 1000 live births in India, compared to 0.3 in the developed countries.

The reduction in mortality achieved so far has been mainly due to public health measures (such as immunization of children and control of epidemics) and improvement in curative services, thanks to the advances in medical technology. Further reductions would depend mainly upon the socio-economic development of the country. This is because a wide variety of factors like education, food, nutrition, shelter, clothing, water, environmental sanitation and personal hygiene influence the health status of people. In other words, provision of health services is necessary but not sufficient to bring about substantial reduction in mortality. An integration of the plans for health with those of the health related sectors such as education, agriculture, social welfare, housing, rural development, water supply and sanitation is, therefore, desirable.

Studies have shown that neither per capita expenditure on health nor per capita income is the most important determinant of health status of people. Literacy, especially female literacy, is the most important determinant of health status. Therefore, literacy campaigns should receive top priority. Promoting literacy is also desirable from the point of view of fertility reduction.

There has been undue emphasis on doctors, dispensaries and drugs, that too of the Western model, for provision of health care. The Allopathic system, which is considered to be the 'modern' system, has been given the position of prime importance in recent decades, while other systems, such as Ayurveda, though popular in the rural areas, have been neglected. The time has come when we should move away from the expensive Western model and encourage and promote the indigenous and other systems of medicine, viz., Ayurveda, Unani, Siddha, Homoeopathy, Naturopathy etc., especially in the rural areas. This is because the people in the rural areas have been using the indigenous systems of medicine and they find them not very expensive. There is need to identify the private practitioners (of the indigenous and other systems) who are popular in the rural areas and provide them training, so that they are better equipped to serve the community. There should be more colleges for teaching Ayurveda, Homoeopathy, etc.

Prevention is always better than cure. The emphasis should be on preventive rather than curative aspects of health care. Therefore, **health education** is very important. The block Health Educator of every Primary Health Centre (PHC) should be provided with a vehicle, so that he can easily carry the health education materials from place to place and impart appropriate health education to people in the rural areas.

Studies have shown that cooking demonstrations of nutritious food prepared out of locally available raw materials have been useful in changing the food habits of people. Therefore, such demonstrations should be arranged, especially in the rural areas. There is also need to educate mothers, especially in the rural areas, about proper infant feeding practices, so that infant mortality rate can be brought down further.

Supplementary feeding programmes arranged for children having protein - calorie malnutrition are useful in improving the nutritional status of the children. Such programmes should be organised in every Primary Health Centre for carefully identified target groups at risk. This would help in the reduction of infant and child mortality.

*Keynote address delivered during inaugural function.

The National Health Policy enunciated in 1982 lays stress on provision of "universal, comprehensive primary health care services, relevant to the actual needs and priorities of the community at a cost which the people can afford ensuring that the planning and implementation of the various health programmes are through the organised involvement and participation of the community, adequately utilising the services being rendered by private, voluntary organisations active in the Health Sector". However, it does not spell out how to bring about community participation. Nor does it specify how to involve the Voluntary organisations. I suggest a modification of the Health Guides' Scheme (earlier known as Community Health Workers' Scheme or Community Health Volunteers' Scheme) in order to achieve both these objectives.

According to the Health Guides Scheme, a Worker/Volunteer is chosen from the community (i.e., village or a population of 1000) by the community to provide certain basic health services to the community. He (or she) is paid an honorarium of Rs.50/- per month and is provided medicines worth Rs.50/- per month through the PHC. A Village Health Committee consisting of five members supervises his/her work. The health guide is given training for a period of three months at the PHC in first aid procedures, treatment of simple ailments, health education, environmental sanitation, etc. He/she receives professional and technical guidance and service support from the PHC staff. He/she is expected to refer patients (whom he/she cannot treat) to the Multipurpose Health Worker or to the PHC or to the district hospital. The Health Guide has to create health consciousness within the community. He/she has to mobilise and organise voluntary effort for environmental sanitation and other health activities in the village; but he/she is generally ill-equiped to carry out this particular task. The preventive and promotive aspects of primary health care are usually neglected. *It is here that a voluntary organisation has a key role to play; it can help the health guide in mobilising the community for active participation in health tasks.*

One private voluntary organisation active in the health field may be chosen from each taluk and encouraged to work in the rural areas by providing suitable grants. It may be asked to provide the necessary guidance and support to the health guides in the taluk who are also volunteers, strictly speaking. In order to ensure community participation for health programmes, the voluntary organisation and the health guide should adopt the strategy of organising developmental activities in the community and winning the confidence of the people. The various activities that could be taken up are kitchen-gardening, adult education, vocational training (sewing, etc.) and income - generating schemes like dairy farming, poultry farming, coffee powder, etc., rearing silkworms, bee-keeping, etc. The voluntary organisation may also encourage development of community organisations such as Mahila Mandals and *Youth Clubs, so that they could be involved in the developmental activities. Thus, the voluntary organisation can act as a catalyst stimulating community participation.*

The honorarium paid to the health guide may be enhanced to Rs.100/- per month, as the present amount of Rs.50/- appears to be small. The amount may be paid through the voluntary organisation, so that it can exercise some control over the health guide. The payment can be made on receipt of the certificate from the Village Health Committee, saying that the work of the health guide is satisfactory. It is desirable that the cost of essential medicines to be supplied to the health guide is borne by the community itself. A sum of Rs.50/- per month may be earmarked for this purpose by the *Panchayat.* This would give the community a sense of participation in the provision of health care. Further, as per the modifications suggested here in the Health Guides' Scheme, the health guide need not depend upon the PHC for the honorarium amount or the medicines; this would give him/her a sense of independence, and he/she would be in a better position to demand health services for the community from the PHC staff.

The members of the Village Health Committee may be provided orientation training at PHC, so that they can effectively supervise the work of the health guide and also appreciate the need for community participation in health care.

NATIONAL HEALTH POLICY - AN OVERVIEW

* Dr.(Mrs) M.K.Vasundhara

Introduction

Since independence the nation has taken forward strides to improve the health of its citizens. There has been a substantial success in lowering the death rates and raising the life expectancy. Small-pox has been eradicated. Plague is almost eliminated; the incidence of malaria is reduced. However, health problems still pose a challenge. Our current infant mortality rate (IMR) is 94 which does not compare favourably with that of Japan which is 4. It is estimated that 3 deaths occur every minute from dehyration due to diarrhoea while tuberculosis claims one life. At any one time, 12-15% of the population is sick, mostly due to communicable diseases. The major brunt of these illnesses is borne by women and children. It is all the more tragic because most of this morbidity and mortality is preventable. 75% of the illnesses are related to poor hygiene and lack of sanitation. The resurgence of the repressed diseases like kala-azaar or malaria and emergence of new diseases like AIDS pose a further challenge. To top it all, the rapidly expanding population takes its own toll. It is estimated that on the economic front, for every 5 points gained, 2 points are lost due to minimum demands of the growing population. It is "tight rope walk exercise" to check the slide down and balance the development because for the overall development, health is a critical factor.

Need for National Health Policy

The Government's concern regarding current situation and its commitment to achieve "Health for All by 2000 A.D." led to evolvement of the National Health Policy in 1983. The enunciation of policy highlights the Government's efforts at removing inequity in the health care delivery by reaching out to the "voiceless" vulnerable population with a health care technology which is **appropriate, affordable** and **acceptable** to the community. For the first time, time as an important resource was realised and targets to be achieved by 2000 A.D. have been clearly spelt out.

Strategy

The Strategy suggested for implementation of this policy is the same as that evolved for Primary Health Care. i.e.

1. Equity in distribution of health care
2. Appropriate Health Technology
3. Multisectoral Approach
4. Community Participation

Equity had to be considered because the health care services were concentrated in urban areas catering only to a small section of the population. The vulnerable population were often neglected. Inadequate referral services led to consumer inconvenience, congestion, duplication and fragmentation of the services leading to increased cost.

Appropriate Health Technology: The curative bias led to wastage of resources in treating over again the diseases which were preventable. A comprehensive health care consisting of preventive, curative, promotive and rehabilitative services was envisaged. The specialisation and hospital based services engulfed the major chunk of the budget favouring the few while denying the essential care to the majority of the community.

The shift is now from specialisation to services which are appropriate, effective, simple and feasible. Such technology promotes self reliance, eg. Oral rehydration therapy to combat dehydration.

Multisectoral approach: Health cannot be viewed in isolation as both health and development are interdependent. Therefore, a multisectoral approach with intersectoral co-ordination between health and allied sectors like food and agriculture, education, water supply and sanitation, social welfare etc., is required for balanced development. This calls for horizontal integration of services at all levels.

Community participation: Sir Joseph Bhore in 1946 indicated the need for community participation. This critical need is not yet realised. There have been some sporadic unorganised ventures which have been shortlived. The dialogue between the planner and the consumer is lacking. Therefore, the envisaged community participation in planning, implementation and evaluation of health care services is minimal.

* *Profession & Head of the Department of Community Medicine Bangalore Medical College, Bangalore - 560 002.*

Broad Guidelines

Certain broad guidelines have been identified in the National Health Policy. They are:

1. Strengthen the ***health care services***
2. Develop ***referral linkages***
3. Restructure ***medical education***
4. Exploit the potential of ***Traditional Systems of Medicine***
5. Promote action oriented ***health service research***
6. Develop ***Health Information System***
7. Attempt ***Population stabilisation***
8. Provide for ***environmental sanitation***
9. Involve ***Non-Governmental Organisations in health care delivery***
10. Highlight the role of ***health education***
11. Reform ***health legislation***

Health Services: In order to make health care services appropriate, the stress is on shifting the bias from "somewhere to everywhere" by establishing a network of services to reach the remotest of the areas. This takes into consideration the population density, topography, transport and priority criteria like tribal, hilly and endemic areas. The curative bias is shifted to comprehensive health care.

The lack of referral services leads to consumer inconvenience, congestion at the specialist centres, duplication and fragmentation of services which add to the cost of the already constrained resources. Therefore, "Back-up support" is provided for by establishing Community Health Centres (CHC) with specialist services. Each CHC will be catering to the needs of 4 to 5 Primary Health Centres.

Critical analysis reveals that the above objectives are not yet realised though there has been considerable expansion of health infrastructure. Essential drugs are not yet available within one kilometer walking distance. The drug policy is topsy turvy with a bias on the price line than the health needs. Control is still vested with Ministry of Petroleum and Industries though drugs are critical for health care needs. It shall rightfully be under the Ministry of Health and Family Welfare.

Medical Education: Due to acculturation, the Medical Education had been "Western oriented" creating a "Culture gap" between the training and health demands. The policy indicates a need for restructuring the syllabi and revision of the training programmes.

Health Service Research: In order to seek optimal solutions to the existing problems, greater stress has to be placed towards operations research.

Health Information System: Hard factual data are needed for planning, evaluation and understanding of epidemiological trends of diseases. Monitoring and evaluation process would permit "Midterm corrections" in the programmes and also ring a timely warning bell in the event of emergence of a new problem. This is how AIDS was detected in U.S.A. Our reporting system needs revamping as the data available are often incomplete and irrelevant. The person who gathers the data and the one who transmits it are not oriented in the process and the relevance of data generation. Further, there is lack of "feed back" of data to the grass root level though communication is one of the fundamental principles of management.

Involvement of Traditional Systems of Medicine: A vast potential of available health manpower already practising traditional system of medicine as well as general practitioners of allopathic medicine remain unexploited in the implementation of National Health Programmes. Their contribution is neither recorded nor recognised. It is high time this manpower availability is exploited to draw them into national health stream in order to achieve the Goal of Health for All by 2000 A.D.

Voluntary Non-Government Organisations have contributed a lot towards community health by extending their services to outreach areas, educating the community; facilitating research; sensitising Government about health needs of community, e.g. Family Planning Programme was first activited by the voluntary organisations. It is indeed a welcome change that the Government is now inviting Voluntary Organisations to extend their role in National Health Programmes.

Health legislation needs to be reviewed and revised to be relevant in context of the current knowledge. It needs to be implemented uniformly throughout the country because diseases or health problems recognise no geographical boundaries.

Health Eduation: The unfortunate loss of limbs and life is avoidable if the community is educated about ways and means to prevent the same. People have a right to information. The messages have to be meaningful to promote self reliance. People have to realise their rights, role and responsibilities for their health care. Health education therefore should be the foundation stone on which health care services should be built.

The "Count Down 2000 A.D." has already begun. It is high time, therefore, that we critically review our progress, remove the impediments and reinforce our activities on war-footing basis to convert the cherished "dream" of National Health Policy into a reality.

CURRENT HEALTH STATUS OF INDIA

* Dr. J.P.GUPTA

According to WHO, "the process of continuous progressive improvement of the health status of a population reflects the health development of the nation". It is a product of raising of the level of human well-being marked by containment of diseases and attainment of positive physical and mental health related to satisfactory economic functioning and social integration. It is based on the fundamental principle that Governments have responsibility of their people and simultaneously people should have the right as well as the duty, individually or collectively, to participate in the development of their own health.

The health status depends upon the overall social and economic development of the country.

There are a number of indicators to gauge health status of the community to the extent to which the objectives and targets of a programme are being attained.

Characteristics of indicators

The ideal indicators scientifically should be Valid, Reliable, Sensitive, Specific and Quantifiable. There is presently no available definition (including WHO definition) containing all the ideal indicators as criteria for measuring the health. Only the measurement of health have been dubbed in the frame work of illness, the consequences of ill health (morbidity or disability) and economic, occupational and domestic factors that promote ill health.

Health is multidimensional and each dimension is influenced by numerous factors (known or unknown); thus the health status may cover the following indicators:-

Mortality indicators, Morbidity indicators, Nutritional status indicators, Health care delivery indicators, Utilisation rates, Indicators of social and mental health, Environmental indicators, Socio-economic indicators, Health Policy indicators, indicators of quality of life and other indicators.

REFORMULATED GLOBAL INDICATORS

- Health for all is continuing to receive endorsment as policy at the highest level.
- Involving people in the implementation of strategies with mechanisms fully functioning or being further developed.
- The percentage of gross national product allotted for health.
- The percentage of National Health Expenditure devoted to local health services.
- Resources for Primary Health Care becoming more equitably distributed.
- The amount of International Aid received or given for health.
- The percentage of the population covered by Primary Health Care, with atleast the following -
  - (a) Safe water in the home or with reasonable access and adequate excreta disposal facilities available.
  - (b) Immunization against Diphtheria, Tetanus, Whooping-cough, Measles, Poliomyelitis and Tuberculosis.
  - (c) Local Health Services, including availability of essential drugs, within one hour's walk or travel.
  - (d) Attendance by trained personnel for pregnancy and child birth and caring for children upto atleast one year of age.
  - (e) The percentage of each element given for all identifiable subgroups.
  - (f) The percentage of women of child-bearing age using Family Planning.
- The percentage of newborns weighing at least 2500 grams at birth and the percentage of children whose weight-for-age and/or weight-for-height are acceptable.
- The IMR, MMR and probability of dying before the age of 5 years (U5MR), in all identifiable subgroups.
- Life expectancy at birth, by sex, in all identifiable subgroups.
- The adult literacy rate, by sex, in all identifiable subgroups.
- The per capita Gross National Product.

Regional Director, Health & Family Welfare, Government of India, Bangalore.

National Goals of Health

(Source: National Health Policy Document)

		GOALS	ACHIVEMENT
•	INFANT MORTALITY RATE (combined) (per 1000 live births)	60	80 (1990 - prov.)
	UNDER - 5 MORTALITY (per 1000 live births)	70	146 (1990)
	MATERNAL MORTALITY (per lakh birth)	200	400 (1990)
	PERINATAL MORTALITY	30-35	50.1 (1987)
•	CRUDE DEATH RATE (combined)	9/1000	9.6 (1990-prov.)
•	CRUDE BIRTH RATE (combined)	21/1000	29.9 (1990-prov.)
••	EFFECTIVE CPR	60%	44.1 (1991-prov.)
@	N.R.R.	1.0	1.6 (1981)
@@	FAMILY SIZE (Rural & Urban combined)	2.3	4.1 (1987)
@	EXPONENTAL ANN GR.RATE	1.2	2.11 (1991) (source Census Report 1991)
@%	NEWBORN WITH 2500 Gms Birth Weight	10%	30% (1990)
@%	OF ANTENATAL CARE	100%	40-50%
@%	DELIVERIES BY TBA	100%	40.5% (1987)
••	IMMUNIZATION - TT (PW)	100%	79% (1991)
	TT School Children	100%	55.6% (1989)
	DPT	100%	82% (1990)
	POLIO	100%	82% (1990)
	BCG	100%	89% (1990)
	DT	85%	80% (1990)
••	MEASLES	100%	90.1% (1991)

Other Indicators

(Source: National Health Policy Document)

		GOALS	ACHIEVEMENT
	LIFE EXPECTANCY AT BIRTH		
	(persons)	64.0•	59.0 (1990)
@@	LEPROSY (% of Disease arrested out of those detected)	100%	55% (1989)
@@	T.B. (% of Disease arrested out of those detected)	75%	65% (1989)
@@	INCIDENCE OF BLINDNESS (%)	0.3	0.7 (1990)
	Female Literacy (1991) = 39.4		
@%	of children suffering from underweight (0-4 yrs.) (By Comez - 8 States)		
	Moderate & severe	= 61 (1980-91)	
	severe	= 9 (1980-91)	
@	Average index of food production per capita (1979-81 = 100)	= 118 (1990)	
@	Daily per capita calorie supply as % of requirements (1988)	= 95	
@%	of household income (1980-85)		
	Spent on - All foods	= 52	
	Cereals	= 18	
@%	of population with access to safe water (1989-90)		
	Total	= 75	
	Urban	= 79	
	Rural	= 73	
@	O.R.T. use rate 91987-89)	= 13	
@	GNP per capita (in US$) (1989)	= 340	

SOURCES -

• - SRS Report 1990

@ - The State of the World's Children 1992 - UNICEF

•• - MCH&FW Quarterly report

@@ - 2nd Evaluation - Country report on strategies for Health for all by the year 2000-1991.

Level of achievement of some norms
All India position as on 30.09.1991

Sl. No.	Parameters/indicators	National Norms	Norms achieved/ established (Approximate)
1	2	3	4
1.	Population covered by a Sub-centre	3000-5000 Pop.	4576
2.	Population covered by a PHC	20,000-30,000 Pop.	27168
3.	Population covered by a Community Health Centre	About 1 lakh Pop.	3.10 lakhs
4.	No. of Sub-centres for each PHC	6 sub-centres	6.0 sub-centres
5.	No. of Primary Health Centres for each Community Health Centre	4 PHCs	11.4 PHCs
6.	Trained Village Health Guide	One for each Village/1000 Population	1.42 Village/VHG 1442 Population/VHG
7.	Trained Dai	Atleast one for each village	1.00 Villages 1002 population
8.	Population served by Health Workers (Male and Female)	M:3000-5000 F:3000-5000	7632 4953
9.	Ratio of HA(M):HW(M)	1:6	1:3.4
10.	Ratio of HA(F):HW(F)	1:6	1:5.4
11.	Average area covered by Sub-centre	-	24.00 Sq.km.
12.	Average Area covered by a PHC	-	142.45 Sq.km.
13.	Average area covered by a CHC	-	1626.93 Sq.km.
14.	Max.radia distance covered by a PHC (in km.)	-	6.73 km.
15.	Max.radial distance covered by a Sub-centre (in km.)	-	2.76 km.
16.	Max.radial distance covered by a CHC (in km.)	-	22.81 km.
17.	Average number of villages covered by a Sub-Centre	-	4-5
17.	Average number of villages covered.by a PHC	-	26-27
19.	Average number of villages covered by a CHC	-	304

Source: Quarterly Bulletin on Rural Health Statistics - Sept. 1991.

Health Infrastructure

- As on 30-9-91

A.

	Total functioning	In Govt. Building	Building under construction	Building to be constructed.
Sub-Centres	130983	51985 (39.7%)	7905	71093 (54.3%)
PHCs	22065	12500 (56.6%)	1389	8176 (37.0%)
CHCs	1932	1179 (61.0%)	284	469 (24.3%)

B. **No. of PHCs & Sub-centres required and in position in Tribal Area -**

- Total Population in TSP Area = 776.84 lakhs
- Total Population in Tribal pocket = 403.02 lakhs
- Total PHCs required for Tribal Area = 3507
- Total PHCs in position in Tribal Area = 3198 (91.2%)
- Total Sub-Centres required in Tribal Area = 23586
- Total Sub-Centres in position in Tribal Area = 18996 (80.5%)

C. **Primary Health Centres with or without Doctors -**
(Information available for 10787 PHCs (18.9% only)

- PHCs with 4 or more Doctors = 427
- PHCs with 3 Doctors = 450
- PHCs with 2 Doctors = 3875
- PHCs with 1 Doctor = 5048
- PHCs without Doctors = 987

D.

- PHCs without Lab. Technician = 3787
- PHCs without Pharmacist = 311

E.

- Total No. of ANM Schools = 476
- ANM admission capacity = 20337
- Total No. of LHV promotional schools = 46
- ANM admission capacity = 3863

F.

- Total Dais trained since inception (as on 30-9-91) = 597761
- Village Health Guide Scheme
  - PHCs covered under VHG Scheme = 4220
  - Villages covered under VHG Scheme (including 948 AHGs) = 531009
  - No. of working VHGs = 335590

G. **- Medical Care Statistics** - As on 1-1-1990
(Source - Health Information India - 1990)

	Rural	Urban	Total
- No. of Hospitals	3167	7005	10172
- No. of beds	95722	506768	602490
- No. of Dispensaries	12747	15557	28304
- No. of Beds	13642	9286	22928

H. **- Disabled Population** (as per 1981 Census report)

- Disabled persons in Rural Area = 969401
- Disabled person in Urban Area = 149547
- Total Disabled person = 1118948

I. **- Percentage of Population below poverty line** (1987-88 Prov.)
(Source - Health Information India - 1990)

- Rural = 32.66%
- Combined = 29.23%

J. **HEALTH MAN POWER IN RURAL AREAS -**

	Category	No.Sanctioned	No. in Position	Vacant (%)
1.	Surgeons	914	676	26.1
2.	Obs. & Gyn.	627	362	42.4
3.	Physicians	535	406	24.2
4.	Paediatricians	512	274	46.4
5.	Doctors at PHCs	25062	21278	15.1
6.	Block Extn. Educators	6154	5763	6.4
7.	Health Assts. (Male)	24891	23273	6.5
8.	Health Worker (Male)/MPW	86713	78538	9.4
9.	Health Assts. (Fem)/LHVs	25044	22282	11.1
10.	Health Workers (Fem)/ANMs	132449	121016	8.7
11.	Pharmacists	19172	17578	8.4
12.	Lab. Technicians	10189	8629	15.4
13.	Nurses Mid-wives	13790	11969	13.3
14.	Radiographer	658	509	22.7
Total category 1 to 4		2588	1718	33.6
Total of category (5 to 14)		344122	310835	9.7
Grand total of all (1-14)		346710	312553	9.9

PERCENTAGE OF GROSS NATIONAL PRODUCT SPENT ON HEALTH -

Estimation of total expenditure on Health and Family Welfare have been taken into consideration on the following basis :-

(1) Expenditure of Ministry of Health and Family Welfare (Centre and State - both plan and Non-plan)

(2) Expenditure on Health and Family Welfare by other Government Departments (except Defence, Paramilitary Forces, Local bodies and P & T etc - since data are not available).

(3) For estimating private expenditure on Health and Family Welfare, the basic assumption is that the private expenditure is double the amount of Public Sector Expenditure (on the basis of National Sample Survey findings).

The findings are -

(A) During Sixth and Seventh Plan the total expenditure on Health and Family Welfare (from Departments of Health and Family Welfare of States, UTs. and Centre only) as percentage of GNP is between the rate of 0.98% (1986-87) to 1.32% (1984-85)

For year 1984-85

$$\frac{\text{National Health Expenditure}}{\text{GNP}} \times 100$$

$$= \frac{\text{Rs.3018.36 Crores}}{\text{Rs.228,118 Crores}} \times 100 = 1.32\%$$

(*Source - Planning Commission*)

(B) As percentage of HNP, the total public sector expenditure (as per above information) has remained within the range of 1.32% (1984-85) and 1.07% (1986-87).

(C) The total expenditure on Health and Family Welfare including the Private Sector is within the range of 4.08% (1984-85) to 3.2% (in 1986-87).

PERCENTAGE OF NATIONAL HEALTH EXPENDITURE ON LOCAL HEALTH SERVICES

Only outlays of Minimum Need Programmes (below district level) has been considered. Therefore the following figures are not showing realistic picture - rather it is an under estimate -

For 1985 - 1990

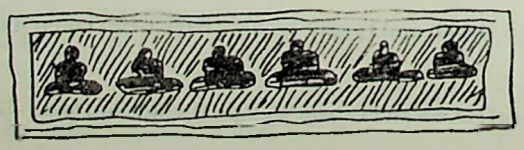
National Health Expenditure elevated

$$= \frac{\text{to local services}}{\text{National Health Expenditure (including F.W.)}} \times 100$$

$$= \frac{\text{Rs.1063 Crores}}{\text{Rs. 2495 Crores}} \times 100 = 42.6\%$$

(*Source - Planning Commission*)

(It excludes Central Health outlay of Rs. 897 crores, Family Welfare outlay of Rs. 3256 crores and outlays for National Health Programmes - because expenditure below district level is not available).



NATIONAL HEALTH POLICY —VIEW POINT OF GOVERNMENT OF KARNATAKA

Dr. C.R.Krishnamurthy

HEALTH CARE SERVICES - KARNATAKA GOVERNMENT

The health status of Karnataka (by almost all health indices) is better than the national average. However much more needs to be done to improve the health of the people. The infant mortality rate is unacceptably high, by itself and compared to the neighbouring states of Kerala and Goa. The maternal mortality rate, percentage of newborn with low birth weight, percentage of malnourished children and women with anaemia are all indices which need marked improvement. The disease profiles show large numbers of the people affected by controllable infectious diseases, including pulmonary tuberculosis, acute respiratory diseases, gastrointestinal diseases, malaria and others. There are districts with high prevalence of leprosy. Kyasonur Forest Disease is seen in Shimoga and neighbouring districts.

The Department of Health and Family Welfare Services provide the following Health care services through:

1. Rural Health component of minimum needs programme
2. Medical Development programme
3. Family Welfare programmes
   - FP, MCH, Immunization, ORT, ARI, CSSM Programmes
4. N.M.E.P. and N.F.F.C.P. (Malaria/Filaria)
5. National Leprosy Eradication programme
6. National Tuberculosis control programme
7. National programme for control of Blindness
8. Prevention and control of other communicable diseases like :
   Diarrhoeal diseases, KFD, JE, AIDS, Etc.,
9. School Health Programme
10. Nutrition programme - Nutrition education and demonstration
11. Laboratory services and vaccine production units
12. Education on Environmental Sanitation
13. Curative Services.

Health and Medical Institutions (Govt. only) in Karnataka

AS ON 31.3.1991

1.	No. of Hospitals	-	176
2.	No. of Community Health Centres Including upgraded PHC's	-	160
	Taluk level	-	129
	Below Taluk level	-	31
	No. of PHC's upgraded	-	48
	Taluk level	-	36
	Below Taluk level	-	12
3.	No. of Primary Health Centres	-	1,198
4.	No. of Primary Health Units	-	626
5.	Total No. of Institutions	-	2000
6.	Total No. of Beds	-	31,434

Number of Sub-centres (District wise) as on 31.3.1991

Bangalore Urban	-	134
Bangalore Rural	-	276
Belgaum	-	578
Bellary	-	240
Bidar	-	217

* *Additional Director (Family Welfare & MCH), Department of Health & Family Welfare Services, Government of Karnataka, Bangalore.*

Bijapur	-	430
Chickmagalur	-	328
Chitradurga	-	441
Dakshina Kannada	-	692
Dharwad	-	571
Gulbarga	-	467
Hassan	-	450
Kodagu	-	158
Kolar	-	359
Mandya	-	364
Mysore	-	672
Raichur	-	348
Shimoga	-	365
Tumkur	-	404
Uttara Kannada	-	302
Total (Karnataka)	=7,793 Sub-centres	

Bed strength in District Hospitals as on 31.3.1991

District Hospital	**Bed Strength**
Bidar	283
Bijapur	316
Chitradurga	405
SC Hospital	
Hassan	344
Dharwad	170
Chickmagalur	279
Karwar	170
Mandya	250
SNR Hospital	
Kolar	260
Raichur	183
Tumkur	325
MC Gann Hospital	
Shimoga	429
Madikeri	410
Total	**3,824**

Bed strength in Major Hospitals, specialised services Hospital and E D Hospitals in Karnataka as on 31.3.1991

	Major Hospital Strength	**Bed**
1.	General Hospital, Jayanagar, Bangalore	200
2.	HSIS Women & Children Hospital, Bangalore	120
3.	K.C.General Hospital, Bangalore	433
4.	Women & Children Hospital, Chickmagalur	88
5.	Women & Children Hospital, Madikeri	210
6.	General Hospital, K G F	110
7.	Women & Children Hospital, K G F	65

Specialised Services Hospitals

1.	Leprosy Hospital, Bangalore	260
2.	T B Hospital, Old Madras Road, Bangalore	234
3.	T B Hospital, Bijapur	110
4.	T B Hospital, Madshedde (DK)	100
5.	Mental Hospital, Dharwad	375

6.	MGM TB Hospital, Malla samudra (Gadag) Dharwad District	64
7.	KNTB Hospital, Kolar	624
8.	TB Hospital, Mandya	148

ED Hospitals

1.	Epidemic Disease Hospital, Bangalore	128
2.	Epidemic Disease Hospital, K G F	24
3.	Epidemic Disease Hospital, Mysore	40

Specialised Hospitals and Institutions

A. Specialised Hospitals as on 31.3.1991

1.	Minto Opthalmic Hospital	
2.	T B Hospitals	- 13
3.	Leprosy Hospitals	
4.	Mental Hospitals	- 2
5.	Cancer Hospitals	- 2
6.	Sri Jayadeva Institute of Cardiology	
7.	Sanjay Gandhi Institute of Accident, Rehabilitation and Physical medicine	
8.	Epidemic Disease Hospitals	- 3

B. Specialised Institutions like Clinics, Centres, Units etc as on 31.1.1991

1.	Central Malaria laboratory	- 1
2.	Drug distribution centres (DDC's)	- 2282
3.	Fever Treatment Depats	- 4180
4.	Urban malaria centres	- 8
5.	Filaria Survey Cell	- 1
6.	Filaria clinics	- 16
7.	Filaria control units	- 6
8.	Virus Diagnostic laboratory, Shimoga	- 1
9.	KFD Trial vaccine unit, Shimoga	- 1
10.	Cholera combat Teams	- 5
11.	Mobile Ophthalmic - cum - Dental units	- 4
12.	Divisional Mobile Ophthalmic Units	- 4
13.	District Mobile Ophthalmic units	- 6
14.	Eye banks - 4	- 3 (Govt) - 1 (Private)
15.	Lady Willington State TB demonstration centre	- 1
16.	District TB Centres	- 22
17.	District Leprosy offices	- 20
18.	Urban Leprosy centres	- 46
19.	Leprosy control centres	- 30
20.	Modified leprosy control units	- 12
21.	Survey, Education & Treatment (SET) Centres	- 677
22.	Epidemiological surveillance team	- 1
23.	Sample survey - cum - assessment units	- 4
24.	Temporary Hospitalisation wards (20 Bedded) Leprosy	- 22
25.	Reconstructive Surgery units-Leprosy	- 6
26.	Model Leprosy control centres	- 1
27.	Leprosy Rehabilitation promotion units	- 3
28.	Voluntary Organisations	- 22
29.	Mobile Nutrition Education and Demonstration units	- 5
30.	Public Health Institute, Bangalore	- 1
31.	Divisional Food Laboratories	- 4
32.	District Laboratores	- 19
33.	Regional Assistant chemical exazminers laboratories	- 9

34.	Vaccine Institute, Belgaum	- 1
35.	Hospital Pharmacies	- 17
36.	Sexually Transmitted Disease Clinics	- 26
37.	Psychaitric clinics	- 127 + (4 mobile Ophthalmic-cum-Dental Clinics)
38.	Burns Wards	- 6
39.	Blood Banks - 60	- 34 (Govt)
		- 2 (Autonomous)
		- 19 (Private)
		- 5 (Voluntary)

HEALTH FACILITIES INDICES - KARNATAKA

(Government 1991 Census Population)

1.	Institution: Population Ratio	- 1:22409
2.	Bed: Population Ratio	- 1:1426
3.	Doctor: Population Ratio	
	excluding Teaching Staff	- 1:10256
	including Teaching Staff	- 1:8335
4.	Auxilary Nurse Midwife/ Midwife Population Ratio	- 1:4905
5.	NURSE: BED RATIO	- 1:8

All Health and Medical Institutions in the State:

1.	Institution: Population Ratio	- 1:19276
2.	Bed: Population Ratio	- 1:957

TRAINING FACILITIES IN KARNATAKA

	Name of Course	No. of Institutions	Duration
1.	Health & F.W. Training Centre	5	
	- orientation training for Fresh Medical graduate of Health	5	2 weeks
	- Supervisory training for Health Assts. (M/F)	5	12 days
2.	Basic M.P.W. training course for Male	5	12 months
	- Training of BHE's in communication	4	2 weeks
3.	Leprosy Training Centres for Para Medical Staff	4	4 months
4.	Health Inspectors Training Course	7	12 months
5.	Promotional L.H.V. Training for Sr.H.A.(F)	4	6 months
6.	A.N.M. Training (M.P.W.) Training for Female	19	18 months
7.	Condensed general Nursing Course	2	12 months
8.	Lab. Technician training Course	1	12 months
9.	Lab. Technician Training Course Jr.	4	12 months
10.	X-ray Technician Training Course	6	12 months
11.	Dental Mechanic and Dental Hygienist training course	1	12 months
12.	General staff Nurses training	9	42 months
13.	Basic B.Sc., Nursing	1	48 months
14.	Basic Nursing Post-certificate Course	1	24 months
15.	Ophthalmic Asst./Refractionist Training Course	4	24 months
16.	Orthoptists/Refractionists and opticians training	1	24 months
17.	Food Inspectors Training Course	1	24 months
18.	Continued education for		
	Medical Officers	4	2 weeks
	Sr. H.A. (M/F)	5	2 weeks
	Jr. H.A. (M/F)	5	2 weeks

FAMILY WELFARE FACILITIES - KARNATAKA

		Nos.
1.	State Family Welfare Bureau	1
2.	District F.WS. Bureau	20
3.	City F.W. Bureau	2
4.	City F.W. Bureau	102
	a. Government - 46	
	b. Local bodies - 27	
	c. Voluntary organisations - 26	
	d. Public sector undertakings - 3	
5.	Rural F.W. Centres	269
6.	Post partum Centres	103
	a. - Type 'A' - 12	
	b. - Type 'B' - 10	
	c. - Type 'C' - 6	
	d. -Sub District level PPC - 75	
7.	Medical Termination of pregnancy	470
	Government - 325	
	Private - 145	
8.	SUB CENTRES 7,793	

DEPARTMENT OF MEDICAL EDUCATION

The Director of Medical Education is incharge of Medical Education and Nursing education including Teaching Hospitals attached to Medical colleges in the state.

There are 19 Medical Colleges in the state
- i. Govt. Medical College - 4
- ii. Private Medical Colleges - 15

There are 13 Dental Colleges
- i. Govt. Dental College - 1
- ii. Private Dental College - 12

- College of Nursing - one (Govt); two (Private)
- Schools of Nursing - 23
  - i. Govt. - 9
  - ii. Private - 14

Hospitals attached to these Medical Colleges provide clinical facilities for students.

INDIAN SYSTEMS OF MEDICINE & HOMEOPATHY

The Department of Indian Systems of Medicine and Homeopathy is headed by the Director of Indian systems of Medicine and Homeopathy.

At the District level, District Health & F.W. Officer of the Department of Health & F.W. Services is the Administrative controlled for the dispensaries of Indian Systems of Medicine and Homeopathy.

There are 6 Govt. Colleges and 14 Private colleges and 23 Govt Hospitals with total bed strength of 750. There are 411 Dispensaries functioning in the state.

There are 12 Ayurvedic Hospitals in the state:

7 Ayurvedic Hospitals at District level (3 Hospitals are teaching Hospitals)
5 Hospitals render service, in rural areas.

Ayurvedic Dispensaries :	364
Unani Hospitals : 4; Unani dispensaries :	32
Homeopathic Hospitals :	2
Bangalore	1
Somwarpet (Coorg)	1
Homeopathic dispensaries :	10
Nature Cure Hospital :	1
Nature Cure Hospital :	5

Yoga wings have been established to provide yoga therapy in Hospitals at Bangalore, Mysore and Bellary

A Sidha wing has been provided in Institute of Indian systems of Medicine, Bangalore.

INSTITUTIONS IN THE STATE AS ON 31.3.1991

	Systems	No. of Hospitals	No. of Beds	No. of Dispensaries
1.	Ayurveda	12	573	364
2.	UNANI	4	111	32
3.	Homeopathy	2	35	10
4.	Sidha	1	10	-
5.	Yoga	3	15	
6.	Naturopathy	1	6	
	Total	**23**	**750**	**411**

No. of Ayurvedic colleges :
Govt. - 3
Private - 6

No. of Homeopathic colleges
Govt. - 1
Private - 7

No. of UNANI Colleges
Govt. - 1

No. of Nature Cure Colleges
Govt. - 1
Private - 1

Training programme for Nurses - 1
Training programme for Pharmacist -
Ayurveda - 1
Unani - 1

Govt. Central Pharmacy - 1

NATIONAL HEALTH POLICY STATEMENT -VIEW POINT OF VOLUNTARY AGENCIES

* **Dr. Shirdi Prasad Tekur**

The Government of India's National Health Policy Statement 1982 recognises the importance of community participation and its role and relationship with voluntary agencies in the following areas -

a) for identification of health needs and priorities, as well as in the implementation and management of various health and related programmes. (P-4)

b) for providing universal comprehensive primary health care services relevant to the actual needs and priorities at a cost which the people can afford, ensuring that the planning and implementation of the various health programme is through the organised involvement and participation of the community, adequately utilising the services being rendered by private voluntary organisations active in the health sector. (P-4)

c) at the community level, to devise arrangements for health and all other developmental activities to be co-ordinated under an integrated programme of rural development. (P-17)

d) for offering organised logistical, financial and technical support to voluntary agencies, while adequately utilising and enlarging the services rendered by them, and intermeshing it with governmental efforts in an integrated manner, especially for those which seek to serve the needs of rural areas and urban slums (P-6, 9, 10)

e) for initiating organised measures to enable development of various indigenous and other systems of medicine and a phased integration in the overall health care delivery system, specially in regards to preventive, promotive and public health objectives. (P-10, 11)

The policy clearly enunciates what is desirable. It also calls for

- decentralisation of services like MCH services to the maximum possible extent (P-14);
- efforts to establish herbal gardens and encourage low-cost, indigenous herbal medicine which is easily available and of certified quality (P-15); and
- for mobilising additional resources for health promotion, ensuring that the community shares the costs of the services (P-16)

All these, for providing adequate care and treatment to those entitled to free care. (P-9)

The policy refrains from providing advice on how this can be done, beyond the pointers it puts out. This gives us a wonderful opportunity to initiate measures to

- take into account local realities in the area of health and development;
- understand peoples' priorities in health and the reasons thereof; and
- consider available resources and constraints, while designing a flexible process suitable for implementation.

Voluntary agencies and their federations have been interacting with the Government of Karnataka at meetings and workshops at various levels, and different times, initiated both by the voluntary agencies as well as the government. Our experience in Karnataka in the last 5 years has shown that with adequate openness and enthusiasm on both sides, this is a creative possibility and can be operationalised. Even though this may not have brought any miracles in Karnataka as yet, the stage is set for a close and meaningful collaborative effort in the decade ahead. Some aspects of this collaboration are:

1. The formation of a Consultative Committee by the Ministry of Rural Development and Social Welfare comprising of Secretaries of all key government departments and representatives of NGOs in Community Development, Education & Health. This was formed

* *Community Health Cell, 326, V Main Road, I Block, Koramangala, Bangalore - 560 034.*

at the initiative of the Planning Commission and has been sustained by the enthusiasm of a series of Development Commissioners and Rural Development Secretaries.

The Consultative Committee has sub-committees including one on Health in which NGO's dialogue with the Director of Health Services and his colleagues on health programmes.

2. Dialogue of NGO's with Perspective Planning Committee of Government of Karnataka on Health, Welfare and Educational Programme.

3. Dialogue with NGO's by Director of Health Services at various levels.
   a) Sub-committee of consultative committee.
   b) 8th Plan document preparation
   c) Dialogue on government programmes organised by Voluntary Health Association of Karnataka.

4. Steps to prepare a comprehensive directory.

5. Steps to increase such dialogue at the district level.

6. Exploration of collaborative efforts.

The key process in all this is frank discussion, feedback from grassroots and mutual consultation in a non-threatening, interactive ethos and a general commitment to exploring the idea of working together.

At this juncture, a purposefully critical collection of impressions of voluntary agencies in their interactions with the Government are called for to understand the varying levels of success in the process of Government - Voluntary agency collaboration.

a) Paritication sought of Voluntary Agencies in government initiated meets are at very short notice, on matters which have been already decided upon and more for purposes of form than actual concern. Also, when government officials attend Voluntary agencies sponsored meets, the response is desultory, condescending and defensive if at all.

b) Voluntary agencies are seen by the government as only alternative service providers or associates for implementation of their programmes. The voluntary agency's roles as issue-risers, demand creators, builders of awareness and alternative planners are largely ignored if not also seen as threats to the Government plans.

c) The Government's understanding is that involvement of Voluntary agency's representatives in consultation automatically means 'peoples involvement' or 'community participation'.

It ingores the feedback and the elaborate process the voluntary agency initiates to bring about peoples participation, since it may mean modification of plans to suit peoples' needs.

d) The Government tends to off-load many of its responsibilities on to voluntary agencies, and puts demands and pressures beyond voluntary agency resources and capabilities without adequate support. The top-down planning and issue of operation guidelines stifle voluntary agency innovations and creative approaches. Also, vertical programmes and focus on selective primary health care programmes are at the cost of comprehensive primary health care.

e) The people's image of the P.H.C. and Government Health staff is very poor. Corruption, inefficiency, political interference and mismanagement are seen to hold sway. They are unhappy with the functioning, attitudes, and quality of services at Government Health Centres.

The voluntary agency plea to tone up the existing governmental system and bring in greater accountability as well as qualitative improvement in their services is largely ignored.

A fall-out of this was seen in the negative experiences of the government health services, with the Panchayat Raj system.

The Governmental Health Services has also been pre-occupied for too long in infrastructural development, resulting in mere structures and no useful function.

f) There has been no change in the Government's perceptions about people working outside the system (NGOs/Volags) or about peoples' capabilities in planning and implementation of programmes.

The Village Health Workers, Health Guides, Anganwadi workers and others who were possibilities in peoples' participation have been co-opted by the system and become lackeys in the governmental process, demanding recognition, more salaries, perks, etc.,

g) Diversity of local culture and traditions and respect for it have never been a string in Governmental bureaucratic processes. So have the traditional and indigenous systems of health care suffered and failed to be recognised for their potential in the dominance of the Allopathic approach to health care.

Is it any wonder, then,

- that people do not participate as much as desired?
- that privatisation and commercialisation of medical services is the norm?
- that people have to take up the call for Rational Drug and Technology policies? and
- that Health policies designed for the poor and marginalised do not reach them?

If community participation as envisaged in the National Health Policy is to make an impact on peoples' health, it needs to include processes that enhance the following:

a) **Information transfer and awareness building programmes for the people** - probably the most important and credible step, considering that this is the weakest link of the present system.

People need to know the whys and hows of each programme, and also to discuss them to explore ideas of how to do them better. Voluntary agencies have something to offer to the Government in ways of interacting with the community as well as creative low-cost communication, which considers people as participants in a process of development rather than 'target-groups' or 'beneficiaries'.

b) **Understanding that people are not a homogenous mass, and are stratified by class, caste, education, culture, gender and other factors.** Positive discrimination towards groups who do not benefit from existing programmes, because they do not participate in local decision making should be a focus. Voluntary agencies have experience in working with such groups and find that supplementing participation with education efforts could strengthen building of health communities.

c) **Peoples' perceptions** of the working of projects and programmes or their own responses to problems must be seen as equally important as statistical/professional/technical situation analysis. This can be sought for by informal focus group discussions rather than formal surveys. When facts are placed before people in an understandable manner, it is seen that education/technical expertise is not a precondition to evolve innovative solutions. These methodologies used by Voluntary agencies in their work can easily be shared with governmental agencies.

d) **Increasing involvement of Voluntary agency** sector in the role of monitors, evaluators, issue raisers, demand creators and trainers and not just 'programme implementors'.

e) **Reorientation programmes** for staff at all levels of the existing infrastructure about this alternate concept of people as participants, where voluntary agencies could share the approaches they adopt.

f) **Monitoring and record-keeping systems** that are not only quantitative, but also qualitative and allow feedback from people and from lower level functionaries of the system who are in closer contact with the people. The motivation of health staff at the lower levels is at a low ebb as they face practical difficulties in their work with people, which they do not seem to have, the required continuing education and support to deal with effectively. Voluntary agencies could help re-orienting them.

All these call for moving away from top-down models to more decentralised and flexible approaches to the diversity of options likely to emerge. We can share the positive and negative experiences of both Government and Voluntary agency efforts especially in the past two decades, learn from each other and evolve more effective methods towards health.

To conclude, we have

- a positive approach to the National Health Policy,
- an opportunity to make our approaches flexible to meet peoples' needs,

- a rich experience between us to learn from, and,
- in Karnataka, a healthy trend of collaboration.

Let us make use of these and get down to making HEALTH FOR ALL by 2000 A.D. a reality in Karnataka.

REFERENCES

1. Statement on National Health Policy - Government of India, Ministry of Health & Family Welfare - 1982.

2. Perspectives in Health Policy and Strategies for the State of Karnataka - a response from CHC - Bangalore.

3. People's Involvement in Planning and Implementation Process - a CHC's response to Planning Commission Initiative.

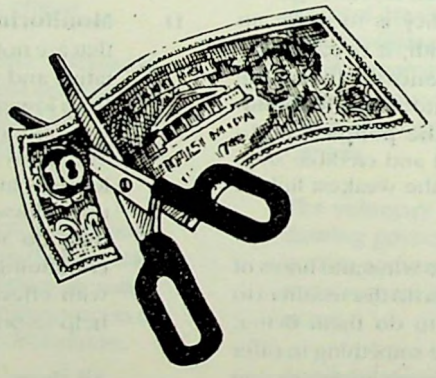
4. Beyond Policy Rhetoric, Statistics and Infrastructural Development : The tasks for the 1990's - A working paper from CHC for the Regional Review meeting on Primary Health Care System Development for Southern Zone.

5. Specific comments on Perspective Plan for Karnataka - drawn up for Department of Health and Family Welfare Services Karnataka.

6. Perspective Planning in Health - A report of the Expert group of perspective planning, set up by the Government of Karnataka.

7. Building the New Paradigm - A Study Reflection-Action experiment in Community Health in India - CHC.

8. Towards a People-Oriented Alternative Health care System – Prof. Duraiyan.



On average, the governments of the developing world are devoting only about 10% of their budgets to meeting the basic needs of their people. More is still being spent on the military and debt servicing than on health and education.

VIEW OF PEOPLES' REPRESENTATIVES IN NATIONAL HEALTH POLICY

* Dr.M.V.Kulkarni
** Dr.G.N.Prabhakara

INTRODUCTION

The character for India's Socio-Economic Development through specific programmes, as a Health Policy was approved in 1983 by Parliament, laying greater stress on MCH care following targets by 2000 A.D. were fixed.

I.M.R.	- below 60
Perinatal Mortality Rate	- 30-35
Pre-School child mortality (1 - 5 years)	- 10
M.M.R.	- Below 2
Babies with Birth weight below 2500 g	- 10%
Birth rate	- 21
Family size	- 2.3
ANC to pregnant women	- 100%
Deliveries by TBA	- 100%
Immunization	- 100%

We have seen integration of Family Planning with other sector and also a change in the Organisations pattern of MCH & FP Services, both in Rural and Urban areas. Training of Dais, ICDS and UIP have been best examples of effort in this regards.

People's Representatives' main objection has been that NHP never takes Social Justice and only talks about poverty alleviation and health care. Further, they are also of opinion that there is no spirit of partnership by agencies.

People have the right and duty to participate in the process for the improvement and maintenance of their health.

Dia: 1

They should recommend the Government encouraging and ensuring their participation.

Small political units or communities can take care of 'Whole Person's needs' rather than a Government which take compartmentalised bureaucratic activities.

2. FUNDAMENTAL POLICY

The Fundamental policies for health that are to be considered are as follows:

1. Health is a right and is a social goal
2. Inequality in Health is a concern.
3. People should participate in planning and implementing Health care.
4. Government is responsible for adequate health of people.
5. Self reliance is possible by peoples' active participation
6. Intersectoral co-ordination is the backbone.
7. Utilisation of available resources for health.

3. ELEMENTS TO BE CONSIDERED

The elements that are to be mentioned for the people's Representative are:

1. Awareness of health problems
2. Means to solve health problems
3. Safe water, sanitary latrines affordable by the people
4. Providing rural quota to rural instead of to an Urban area

Appropriate Planning Starts with people

* *Professor and Head of the Department*
** *Lecturer, Department of Preventive and Social Medicine, Government Medical College, MYSORE.*

5. Legislative support, gathering for above items there is a need of more sub-centres, community health centres, Trained Health guides and trained Dais.

Involvement of all category of People's Representatives from the existing Infrastructure have been there from time immemorial. These are (a) Corporation (b) Muncipality (c) Boards (d) Village Panchyat (e) Mandal Panchyat (f) Zilla Parishat (g) Religious Bodies (h) Co-operative bodies (i) District Health and F.W. Offices (j) Director of Health and Family Welfare (k) State Ministry (l) Union Ministry (m) Voluntary Health Organisation.

People representatives should have a note of the following elementaries

1. All people in every country will have at least ready access to essential health care and to first level referal facilities.
2. All People will be actively involved in caring for themselves and for their families as far as they can and in community action for health.
3. People shall share responsibility with Government for health care of their members.
4. Government should assure overall responsibility for health of their people.
5. Safe drinking water and sanitation facilities will be available to all.
6. All people to be adequately nourished.
7. All children and pregnant mothers to get immunised
8. Communicable diseases shall no more be a public health problem.
9. Look into non communicable diseases and Mental Health by controlling life style and psychosocial environment.
10. Availability of essential drugs.

Successful pursuit of health policy will depend on the authority being responsible for it, on behalf of Government. At present those are (a) Ministry (b) Directorate (c) Corporation and Municipality (d) Zilla Parishat at different levels, Here ensuring political commitment is to channelling health activities to the people.

4. EXISTING PROBLEMS IN THE AREA

Our great problems is not that of promoting the pursuit of new knowledge, it is the suitability and adaptability of existing structure and functioning of Health Services at large that matters in Health for All.

It is still being observed that —

a) Raising cost of Medical Treatment
b) No aminities for safe water and sanitation
c) Over reliance on Mass Media is becoming dangerous
d) Poor education becoming carrier for utilisation of knowledge.

A) PROBLEMS IN APPROACH:
- LACK OF CLEAR NATIONAL HEALTH POLICY
- POOR LINKAGE OF HEALTH SERVICES WITH OTHER NATIONAL DEVELOPMENT
- LACK OF CLEAR PRIORITY
- NO COMMUNITY INVOLVEMENT
- INAPPROPRIATE TRAINING OF HEALTH PERSONNEL

B) PROBLEMS IN RESOURCE:
- INADEQUACY AND MALDISTRIBUTION
- NON-UTILISATION OF ACTUAL AND POTENTIAL RESOURCES
- RESTRICTED USE OF PUBLIC HEALTH WORK
- INCREASING COST

C) PROBLEMS IN GENERAL STRUCTURE:
- NO EFFECTIVE PLANNING
- WEAK DEVELOPMENT OF CONCEPT OF TOTAL SYSTEM

D) PROBLEM IN TECHNICAL ASPECT:
- NO HEALTH EDUCATION
- NO BASIC SANITATION
- NO COMMUNICATION
- NO TRANSPORT
- NO HEALTH INFORMATION

5. GENERAL FORCE INVOLVED:

Support by other related sectors viz. Agriculture, Housing, Water supply, Sanitation, Public Works and Communication, Education, Mass Media are most important.

People's Representatives in Local Government can ensure that community interests are properly taken into account in planning and implementation of programmes. Public services should be accountable to the communities. The desirability of coordinating at the local level, the activities of various sectors involved in Socio-economic development and the crucial rolè of community in achieving them, make peoples representatives an essential and effective component.

A clear national health policy is needed which will promote community cohesion around efforts for health and related development, will foster the coordination at the local level of all sectors' programmes that have a bearing on Health Care.

will build up the capacity of communities to make up their health and other social aspirations known, and will ensure that the community controls both the funds it invests and personnel providing it. Mutual support between Government and people should be reinforced by mutual information feedback. It is the responsibility of Government to stimulate this kind of support to set up necessary intersectoral co-ordination and different administrative level to pass legislation, to provide sufficient human, material, technical and financial resources. For public reach, it needs easy access to the right kind of information concerning their health situation and how they themselves can help to improve it. In certain area or situation, people's participation can be legislated.

Non-Government Organisations can make a very useful contribution to health services, precisely because of working within the community. They have same responsibility as Government Agencies in the sense that they provide technical and financial support to nation and would do well to ensure that these are channelled into the Health Service System.

6. WOMEN FORCE INVOLVED:

Women a force for renewal of Health Activities in a nature of policy is attributed. Women influence health care in many ways, as mothers bearing the main responsibility for family health, as Agricultural workers, as Primary Health Centre Workers, birth attendants, Educators and members of community groups. If an educational programme does not recognise women as important agents of change and learning, it will not succeed in developing full community involvement and cannot obtain the people's responsibility.

7. NATIONAL PICTURE:

In India, at least 3 forms of influential environment can be seen. They are (a) Political environment (b) Religious environment and (c) Social reform environment.

High technology medicine is getting quite out of hand and leading health systems in the wrong direction, i.e., away from health promotion for the many, towards expensive treatment for the few.

Modern Medicine, is not accessible to the poorer social classes. And most forms of disease are more prevalent among people living in poverty. This shows the link between health and socio-economic conditions.

Among the organisations that have been used or suggested for mobilising support for Primary Health Care as National Health Programme are (a) Political parties (b) Women Organisations (c) Youth organisations (d) Trade Unions and (e) Religious or Ethnic bodies. Whenever possible, local plans and priorities should be based on information about the actual health needs and problems of all members in the community. Groups at risk can be identified along with special needs and priorities can be established and progress monitored on the basis of information.

Individuals and families should assume responsibilities for their own health and welfare. This entails penetration of services to target population.

In our Society, stress is laid on overall political and economic context; power, finance, decision making all not by people, but normally by people's representatives. Hence country side effort is necessary for a common setting of peoples representatives.

Elected bodies of citizens have been put incharge of local health and social services at District and Regional levels. Here wide involvement of people, in the improvement of their own health will not be there. Appointment of representatives to the adivsory board of local health facilities is to be geared up.

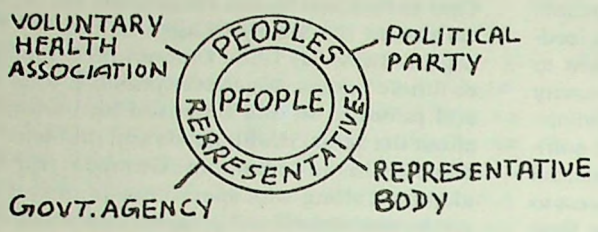
The financial contribution by voluntary organisation is relatively small, but their contribution to health is often significant. Those local, National and International Organisations have their own motives and provision in the allocation of resources. This factor should be carefully considered when assessing that role in health care. They direct their limited resources to the most needy segment of population.

8. COMMUNITY EFFORT

Cultural, economic and political circumstances of India influence all aspect of support to Health services. There is need for understanding of the relations between effective community involvement and propitious political and economic conditions.

The mobilisation of people for health development requires their participation.

The collective organisation in India has been as follows:



In British ruling without any contribution people used to get services. Now also that strong tradition has been seen in our country. We have organisations disharmony. Various social and political forces play in every Mandal Panchyat and Zilla Parishad hampering the participation. Hence peoples involvement is slow and halting. What people see as their real need are not seen by service givers. This amounts to ignoring peoples need. A professional man always says that he is better qualified and that he knows better than any one.

9. INTEGRATED ACTION:

Discussions and conclusions at the Joint Conferences of the Central Council of Health and Family Welfare and the National Development Council have always been directed towards a common pattern of infrstructure in Health and Family Welfare Services in India. Whether it is in Medical Education, Legislation, Standard maintenance of vaccine or drug; there has been common consensus for a common pattern.

Evolution of National Health Policy is one such major step for an integrated action in achieving this goal.

Communication strategies to motivate a positive attitude could have been another step in achieving a goal of National Health Policy.

Thus all our departments, which contribute for socio-economic development of India, rely upon intimately related sectors of administration and politics. It is of vital importance to ensure effective co-ordination between Health and People's Representatives. Contents and priorities of programmes are to be viewed by people or people's Representatives in their effective implementation. Integrated Programme of Rural Development (IRDP) is a standing example in this regard.

10. COMMENT FROM THE PEOPLE:

Following upbridged comment demarcate people view in National Health Policy.

- Health Facility to one and all, equal with Urban-Rural, Male-Female, Young-Old.
- Poor to have free service. Rich to have paid service.
- Political unrest, violence and law breaking are by lack of understanding; provide better understanding.
- Region, District and Urban should have programmes by Regional, District and Corporation Offices.
- Without potable water and sanitation is it health facility?
- India is not poor, money is going down the drain, use for proper health care.
- Older have struggled. Younger are yet to realise the importance of sweat and toil.
- Administrators, both Government and elected body, have done considerable haram by undermining the concept and need of excellence in every sphere of action.
- Democracy run on present election procedure puts a premium on powers.
- No Co-operative community care by Zilla Parishat.
- No copying from USA or UK. Make Health available to all in their economic status.
- Health care is not just by doctors. But by others also. Say Health Board.
- Hospital admission criteria is priority to certain groups. Why not policy common to all?
- Allow us to have Home, Herbal or Nature even. Do not insist with chemicals.
- Field workers of all departments to help Health services.

11. CONCLUSION AND REMARKS:

National Health Policy is an expression of our Health. Hence national strategy should include broad lines of action in all sectors involved to give effect to that policy. What has to be done? Who has to do it? During what time? With what resources? It is a framework leading to more detailed programming, budgeting, implementation and evaluation.

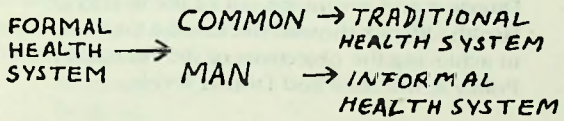
We mean Health that begins at home, schools, factories. It is there, where people live and work that health is made or broken. It does mean people will use better approaches than they do now for preventing diseases and alleviating unavoidable disease and disability and have better ways of growing up, growing old and dying gracefully.

Let this mean even distribution among population whatever resources for Health are available.

Peoples Representative in Health Policy is a sober one. But related strategy appears good, clear cut and defined. They deserve giving effect to these actions. Here achieving acceptable level of health as part of socio-economic development in the spirit of social justice is to be indicated.

Why should we not involve General Practioners and Link Insurance Scheme? This can be answered in the policy.

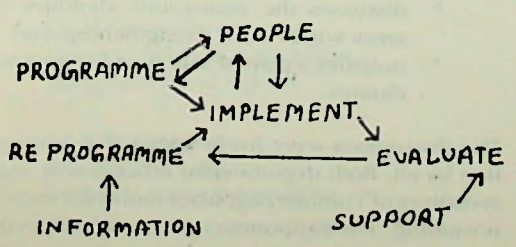
Simplified Medicine programme or elementary Health by any body should be envisaged in the policy.
Two way Radio scheme for advice and supervision seems to be very good.



In the above figure it is pointed out how we are driving behind man, whereas Man is running behind Traditional and informal system.

Hence we should think of

a) Co-operative Rural Dispensary
b) Family Survival Assurance Plan
c) Integrated Child Care
d) Integrated Health Nutrition
e) Integrated Maternal Care
f) Integrated Family Care



In each action involvement of people and/or peoples Representative has an effect on any policy making.

In view of problems posed, we should make an endeavour to provide basic amenities, to provide essential drugs, to provide basic education. Women force and community force are an assets in our endeavour of uniform pattern of Health Services.

Integrated Action is an injectable solution, which has a miracle in community healing.

REFERENCES

1. Alma - Ata Ten years after - WHO 1986 (Near letter No.20)
2. Alternative Approaches to Health care - ICMR New Delhi 1977
3. Alternative approaches to meeting basic Health needs in developing countries. UNICER - WHO Joint Study - WHO 1975
4. Global strategy for HFA by the year 2000 - WHO 1981
5. Health for all by the year 2000, the role of Health Education VTH Gunaratre Int. Journal of B.E. Vol. XXIII No. 1, 1980.
6. Health System support for Primary Health Care - P.H.Paper No. 80 WHO 1984.
7. Leadership for Primary Health Care - P.H.Paper No. 82 WHO - 1986
8. Managerial process for National Health Development - WHO 1981
9. Medical Care, the changing needs and pattern - Sir Godber Ciba Foundation Lecture - 1970.
10. National Health Policy - Statement - Govt. of India Ministry of Health and Family Welfare, New Delhi - 1982.
11. Planning India's Health - K.S.Sanjivi, Orient Longman 1971.
12. Primary Health Care - Joint Report WHO & UNICER - WHO 1978
13. Primary Health Care - The Chinese Experience, WHO 1983
14. Text Book of Preventive and Social Medicine, B.K. Mahajan, Jaypee Brothers 1991.
15. Text Book of Preventive and Social Medicine, J.E. Park, 12th Edtn. 1989.

CLARIFICATIONS

The papers evoked great interest among the participants. The members required many clarifications and made various comments. They wished to have a discussion on certain issues raised by the resource persons. Hence the discussions were continued for 45 minutes after lunch. There was a lively and useful discussion. Among the issues raised were

- Voluntary organisations operated more in the urban areas.
- Voluntary organisations are not utilising fully government facilities
- Zilla Parishads are strong links and have to be involved actively in health care.
- With the existing budget and release of funds, it is not possible to achieve the objectives.
- The department of Health and F.W. Services does not have the organisation to implement the Policy.
- District health committees should be reactivated with representatives of Voluntary Agencies.

Dr. T. Ranganath Achar made a number of useful observations. The implementation of the programme is often slow inspite of Government efforts. People are not often prepared to accept the programmes. He assured full co-operation with Voluntary agencies. Governmental responses to Voluntary initiatives will be good.

Dr.C.M. Francis, Moderator, complimented the Resource Persons for their well searched presentations. The participation from Government and Voluntary organisations was simply wonderful. The presence of the Director, Regional Director, Additional Director, Joint Director, Divisional Joint Directors and seventeen out of the twenty District Health Officers showed the interest taken by them in achieving the objectives of the National Health Policy at the State and District levels.

GROUP DISCUSSIONS

9.4.1992 : 2.30 p.m. - 5.00 p.m.
10.4.1992 : 9.00 a.m. - 1.00 p.m.

Group discussions were held during the afternoon of day - 1 and continued till the afternoon of day - 2. Four groups, with representatives from both Government and Voluntary sectors were formed. The issues discussed were

PRIMARY HEALTH CARE
HEALTH EDUCATION
INTER-SECTORAL CO-ORDINATION
HEALTH INFORMATION SYSTEM

The following process was followed in general : The group

- goes through the National Health Policy, with particular reference to the specific topic,
- discusses the issues and identifies the areas which need strengthening, and
- prepares a plan of action and recommendations

The discussions were lively with active participation by all. Both departmental officials and representatives of Voluntary agencies found the exercise rewarding. The Rapporteurs presented the recommendations at the plenary session on the afternoon of the second day.

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RECOMMENDATIONS

1) **Health Budget** There is need for a substantial increase in the budget allocation to the Health sector. There must be equity in the allocation of health budget to the rural and urban areas based on population.

2) **District Health Policy** Decentralisation of planning, implementation and evaluation of the health and health related programmes to the district level so as to formulate a District Health Policy according to the needs of that particular district. Procedures to be simplified for the involvement of the Voluntary Organisations to facilitate proper functioning.

3) **Existing PHCs** Existing health centres should be made fully functional before any expansion programme is taken up, except for tribal, hilly and backward areas where there is a need.

4) **Referral system** Community Health Centres and sub district level hospitals must be well equipped and specialist posts filled up.

- National norm for the proportion of CHC to PHC may be maintained.

- Specialists at CHC and Sub District level hospitals may provide their services to the neighbouring PHCs as per the needs.

5) **Training and Reorientation**

- Facilities are to be ensured for training various Voluntary workers for Primary Health Care both by Voluntary Organisations and Government.

- Required technical skills are to be passed on to the workers

- The quality of training must be maintained.

- Reorientation of Voluntary Workers from time to time.

- More involvement of women volunteers to be encouraged for better community participation.

6) **District level Epidemiological Cell**

- Need for a full fledged epidemiological cell at the District level with field stations complemented by Voluntary services.

7) **The support of Primary Health Care**

The Voluntary Organisations may support the institutions under PHC or in their areas by establishing the curative centres, enhancing the Government efforts. They need to coordinate with the Government health institutions for necessary laboratory investigation, etc. The government institutions can provide logistic and technical support including Continuing Medical Education.

8) **Specialised Care**

The Non-governmental organisations equipped with the specialised curative services may supplement the Government Organisations not having such facilities locally by providing free care to the poor people and running paying clinics for the affluent sections.

9) **Mental Health care programme**

Programmes to provide the physical and social rehabilitation may be expanded in a phased manner. Voluntary Organisations may be involved in this programme.

10) **Mobility**

Availability of adequate mobility may be ensured to all level functionaries in government and voluntary sectors to facilitate provision of health services.

11) **Integration of indigenous systems of medicine**

There is need for integration of indigenous systems of Medicine with Modern (allopathic) Medicine in Primary Health Care as regards curative, preventive, promotive and rehabilitative services to the extent possible.

11) **a) Orientation of staff**
There is need for orientation of existing health staff.
b) Adequate budget allocation is needed for comparative research.
c) Prescribers of drugs (whether they belong to the allopathic or indigenous systems of medicine) should have sufficient knowledge and skill in their use. If necessary, they may be given short training programmes.

12) National Drug Policy
It should be an integral part of the National Health Policy

1. There is need for a Rational Drug Policy.
2. There is need for formulation of essential drug lists for the various levels of health care.
3. Adequate production and distribution of essential drugs are to be ensured.
4. Central registration of all formulations whether they be allopathic, ayurvedic or other preparations should be mandatory.
5. Drug control machinery must be strengthened.
6. Control of drug pricing must be ensured.
7. Drugs should be made available under generic names.

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The Group focussed on Health Education

The Group first determined what aspects of health education should be discussed and for whom it should be. The consensus was that the group discusses Education for Health, with focus on People in general.

I. Why Health education?

1. Make people Health conscious and develop the knowledge, skills and attitude of the people to take action for better Health.
2. Make people competent to identify the health needs, available services and ask for those services as needed.
3. Help people avoid superstition, harmful traditions and customs and irrational medical practices, and promote the customs and tradition which have a positive impact on health.
4. Improve life styles for health and quality of life.

II.Present status of Health education

1. A dent has been made in health education. There is a Health Education Bureau at the State and District level. District health education Officer and other personnel and infrastructure. But Health education is not given adequate priority.
2. The staff do not know their job well. Their services are often used for other purposes. Funds available are not properly utilised.
3. Health education administration is too much centralised. There is not enough flexibility at the District or peripheral level. Funds are often released towards the end of the year.
4. Communication strategies are often outmoded using inappropriate language. Often negative methods are adopted.
5. General literacy, especially of girls, is low. There is not much Health education material in general education, books and syllabus.
6. Situations like out-break of epidemics give us opportunities for health education but are not utilised effectively.
7. Not enough attention is given to improve life styles. Some of the measures of Government affecting the use of tobacco and alcohol are counter-productive.
8. Voluntary Organisations are not able to use the health education resources and materials available with the government and vice versa.

III.What should be done?

1. Better use of media, including the Mass Media, Street Plays and Folk Media, pictorial representation for illiterate people (wall posters, paintings etc.); personal communication is very important.
2. Emphasise positive aspects.
3. Qualitative improvements of health education and its evaluation.
4. Give greater priority for health education. There is also a need for better supervision.
5. Better education materials for school children and educational institutions, debates, quiz programmes and essays. All teachers must be trained in health education.
6. A local or District Committee could suggest ways and means of health education and periodical Assessment.
7. Better rapport between health workers in the Government and Voluntary sector to make better use of available materials. There must be better co-ordination and co-operation between various sectors.
8. Committees must be formed or reactivated at various levels
   (i) PHC/Block level
   (ii) District level with the Dist. Health & F.W. Officer as chairperson
   (iii) State level - Apart from the health, other sectors and Voluntary Organisations must be members, as health is not the domain of health sector alone.

   A Directory, if not available, should be prepared of all the Voluntary Organisations working in the different areas and levels. The available Directory may be updated.
9. Reorientation is necessary for both Voluntary Organisations and government functionaries.
10. The possibility of Voluntary Organisations adopting PHCs or sub centres must be considered.
11. Duplication of work by Government and Voluntary Organisations should be avoided to the extent possible demarcating areas of activity.
12. The possibility of bringing out a Newsletter (monthly/quarterly) should be explored.
13. There are guidelines given by Government of India with respect to co-operation between Government and Voluntary agencies. This must be made known to the Voluntary organisations. Wherever necessary, modification should be brought upon.
14. We must involve local and national leaders and elected people's representatives. There is need for political commitment.

IV.PLAN OF ACTION FOR COMMITTEES

1. 'Committees' must be formed at the Block (PHC) level, District and State levels within 6 months.

   Where committees are dormant, they must be reactivated.
2. The committees will have wide membership with officials, including related sectors, Voluntary organisations and elected people's representatives.

(a) Block level committee:

Membership: Officials belonging to health, education, agriculture, animal husbandry and other sectors.

Representatives of Voluntary organisations working at block level. Elected representatives to the mandal panchayat.

The Committee will have the following functions:

(i) Identify 'local health problems', find out their causes and the reasons for persistance of such problems.

(ii) Identify 'barriers of communication'.

(iii) Prepare and implement a calender for action on annual basis and evaluate the performance at the end of each year.

(iv) Help and guide health education at the village level.

(If considered desirable a committee can be formed at the village itself), and

(v) Meet once a month.

(b) District level committees

The D.H. & F.W.Officer will be the chairperson and the DHEO will be the member-secretary; other officers including officers drawn from the Information Department will be members. There will be representatives of Voluntary Organisations functioning in the field of health in the district and elected representatives of the people (Zilla Parishad).

Functions

The Committee will

(i) review activities of health education.

(ii) integrate the functions of different sectors with respect to educational activities and government guidance to the Block level committee helping them to solve their problems; wherever necessary and feasible, the committee will visit the block, and

(iii) the meetings will be held quarterly.

(c) State level committee

- The Director of Health & F.W.Services will be the Chairperson.
- The Joint Director (HE & T) of the Directorate of Health & F.W.Services will be the member-secretary.
- The representatives of District Health Office and other sectors. Representatives of Voluntary Organisations working at the State level.
- Elected people's representatives (MLAs) and other leaders.

Functions

The Committee will

(i) review, integrate and monitor health education at the state level and also other levels,

(ii) ensure that the health education materials are updated regularly and

(iii) meet half yearly.

IMPLEMENTATION

A plan of action has to be drawn up with a time frame for all the recommendations as detailed above.

SOURCE: THE TRIBUNE, JUNE 1991.

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GROUP III : INTERSECTORAL CO-ORDINATION IN HEALTH CARE DELIVERY

The Group discussed at length "Intersectoral Co-ordination" in Health care Delivery keeping in the background relevant sections in the National Health Policy Document and arrived at following conclusions :

Public Health Act

There is need to have a comprehensive Public Health Act taking into account new problems like environmental pollution. The existing old Public Health Act is not relevant. The new Act must extend to the whole of Karnataka State.

Health Insurance

May be promoted among the people to participate economically for utilisation of available Health Services. The group further recommend constitution of an Expert committee to go into the details of scope of Health Insurance and how people can participate economically.

The Group felt that Intersectoral Committees be formed at different levels to facilitate effective

intersectoral co-ordination. The group delineated who all should be the members of the committees.

I. Village level Committees

Village Accountant - Chairperson Auxiliary Nurse Midwife - Member Secretary

Agricultural Asst., Anganwadi workers, Teachers, Presidents of Mahila Mandals, Mahila Swasth Sanghas and Youth Clubs (Members).

II. Sub-Centre level committee

Mandal Secretary - Chairperson
Auxiliary Nurse Midwife - Member Secretary
Agricultural Asst., Anganawadi Worker, Teachers, Presidents of Mahila Mandal, Mahila Swasth Sanghas and Youth Club (Members).

III. Primary Health Centre

Tahsildar/Asst. Commissioner - Chairperson
Medical Officer, PHC-Member Secretary

Block Development Officer; Asst. Director of Agriculture; Child Devt. Project Officer; Asst. Education Officer, Asst. Executive Engineer, Social Welfare Officer, Range Forest Officer, Asst. Director of Animal Husbandry, Head Master of High School, Representatives of Voluntary Organisations (Members).

IV. District level Committe

Existing Committees to have additional representatives of Voluntary Organisations as Members.

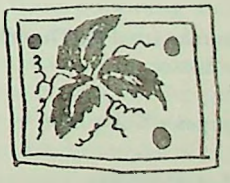
V. State level Committees

Existing Committees to have additional representatives to Voluntary Organisations as Members.

The Committees at Village, Sub-Centre and Primary Health Centre levels to meet once a month; District level Committees to meet once in two months; State level committee to meet once in three months.

The Groups further delineated functions of committees as follows;

(i) identify existing health problems;
(ii) problems of health and health related sector to be addressed with a wholistic approach ensuring co-ordination of activities of all the Government Departments and Voluntary Organisations;
(iii) plan programmes to be implemented taking into consideration all locally available resources - Technology, Material and Manpower etc.;
(iv) committees to take note of banned drugs; educate gramsabhas regarding prevention and control of various diseases and banned drugs;
(v) review and evaluate programmes periodically in the meetings;
(vi) The proceedings of the meetings to be recorded and made available to members and to higher and lower functionaries and the people.
(vii) The District level Committees to recommend to authorities concerned to procure only essential drugs and supply to health centres.
(viii) The State level committee to recommand to authorities to procure only essential drugs, in adequate amounts and to match the drugs procured with the existing health problems.
(ix) The available infrastructure for training in the Government to be made open for use by Voluntary Organisations also. (Health and Family Welfare Training Centres; District Training Institutes) and vice versa.



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The Group discussion started with reading the relevant parts of the National Health Policy statement focusing on this topic.

The group decided to focus first on how the system is at present operating and consider the positive aspects and lacunae.

1. Channels of Information

Field Staff to PHC to DHO to DJD to Directorate of Health Services

There is a feed-back system going back along the same channel. The information transmitted is mainly in the form of figures (numbers) while the other details are also present at the point of collection.

2. Data collection

The chief person collecting information from the field is from the Government - Dept. of Health & F.W., to be specific, the Female and Male Health Assistants.

Voluntary agencies collect different types of information depending on their activities. They may transmit it to the government on request, and that too, at different levels.
eg: Vital statistics (Births/Deaths) are given to PHC/ Panchayat level.

Disease profiles are transmitted directly to Directorate of Health Services once a year from the Hospitals. There is no duplication of reports in services like U I P., where vaccines are involved, but it may occur in other areas.

3. At Field Level

The information collected is incomplete because of various problems :

a) Educational and language problems of female health assistants.
b) Information may be second hand
   Eg: ANM collects from Anganwadi worker.
c) Too much of data. Each programme has its own needs to be fulfilled. Hence the worker in the field is over burdened.
d) The reporting formats are complicated and are not easily understood by some field workers.

4. At P H C Level

a) Compilation of reports from field.

b)In addition, data generated at P H C itself from its out-patient/In-patient records. Here again, there are problems of classifying data fraom inadequateely maintained registers.
eg: Disease Statistics Register has 150 diseases classified
(This has recently been reduced to 27)

5. At D H O Level

a)Compilation of reports from PHCs.
b)The data compiled undergoes a 10% verification by statistical officer and 2% verification by D H O.
The amount of data here is very large and requires about 3 days of compiling work. There is data generated at District Surgeon level in Govt. Hospital as regards to number of patients treated IN as well OUT patients. This is to be sent directly to Directorate for further comilation.

ALL DATA GENERATED HAVE TO BE FOR RELEVANT EPIDEMIOLOGICAL NEEDS OF HEALTH OF THE PEOPLE.

6. General Comments

a)Vital statistics reporting (Births and Deaths) has improved after statutory requirements have made recording necessary for various reasons where Birth and Death certificates are required.
b)Notifiable Diseases/Epidemic occurrences reporting is mainly if the diseases are of fatal nature, or create problems, eg : in Gastro-enteritis reporting.

SOLUTIONS

1. Only one person/agency in an area is to be responsible for H I S collection, preferably the Government Agency.

2. A simple format of reporting for field worker - preferably one page.
eg : I E C proforma intorudced 3 years back of a single page can be updated and used.
Also adequate printed forms is required to be supplied.

3. A simple and standardized coding system at P H C corresponding to W H O classification of deseases to be worked out for Disease Statistics Register.

4. Computerisation of information system at DHO level. Hospital data from voluntary agencies in the district to be sent to D H O level

5. Voluntary agencies to attend P H C meeting every month and exchange data and information and avoid duplication.

6. A mechanism of involving local people like In Arogya Mahila Sangha at Mandal Panchayat level with members from each village

No incentives or honoraria should be given for helping in H I S. Only transfer of knowledge, especially on health takes place for the local group.

The group then decided to focus on National Health Policy guidelines and priorities it sets in the following areas:

1. **Nutrition**: There are various programmes which have gone through the stages of base line survey and partial implementation.
eg: Vitamin A prophylaxis/Anaemia (Iron & Folic Acid) Goitre/ICDS - supplementary nutrition etc.,
- Concurrent evaluation of these programmes is to be done for upgradation, stopping or adding on services.
- Strengthening of Research aspect in the HIS at State and District level for utilizating H I S data well.
- Teaching, training and other Research Medical/Health Institutions to be utilized for focussing on Public Health Problems.

2. **Food/drug adulteration**
- Incidence of food poisoning and unusual health effects of durgs are to be reported.
- Drug inspectorate work is to be intensified to generate data, as the people are made aware of this problem.
- It would be needed to make N H P priority areas to be reported as part of H I S
- We also need qualitative data in addition to quantitative data. Though this cannot be done routinely, it can be done with local peoples orgnaisations.

For occupational diseases, no system for reporting or studying is available
This has to be created, with special focus on Agriculture and rural occupations

PLENARY SESSION : 2.00 p.m.
Moderator : Dr. C.M.Francis

Individual groups presented the observations, recommendations and conclusions of each group

Group I	:	Primary Health Care	Presented by Dr. H.R. Narayana Murthy Div. Joint Director Bangalore
Group II	:	Health Education	Presented by Dr. G.V. Nagaraj Joint Director (Immunization) Health & F.W. Services Bangalore.
Group III	:	Intersectoral Co-ordiation in Health care delivery	Presented by Mr. S.M.Subramanya Setty Asst. Pofessor in Health Education NIMHANS, Bangalore.
Group IV	:	Health Information system	Presented by Dr. S.P. Tekur Community Health Cell Bangalore.

Hon. Health Minister of the Government of Karnataka. Sri. G. Puttaswamy Gowda, joined the plenary session. Dr. H. Sudarshan, Treasurer, VHAK welcomed the Hon. Health Minister. Dr. S. Pruthvish, Member, VHAK presented the conclusions arrived at the workshop, on behalf of the participants and organisers.

After the presentation of conclusions, the Hon. Health Minister asked for clarifications on the recommendation for Decentralisation of planning, implementation and evaluation. The participants deliberated on this issue. It was observed that Karnataka is one of the states which has attempted to decentralise planning to District level. Appreciating this aspect the group felt that there is much scope to improve in thia area. Dr. T. Ranganatha Achar, Director os Health & F.W. Services, Dr. C.R. Krishnamurthy, Addl. Director, Health & F.W. Services, Dr. C.M. Francis, Director, St. Martha's Hospital and Dr. H. Sudarshan, Treasurr VHAK provided clarifications to the Hon. Health Minister.

Hon. Health Minister Sri G. Puttaswamy Gowda addressed the gathering. This attempt by VHAK, VHAI and Department of Helath & Family Welfare Serivces in organising two days worksship and forwarding their recommendations to the Government is commendable.

Role of Voluntary Organisation in Health Care assumes major importance. This is a model as well as guiding example. Since both Government and Voluntary Organisations will be involved in similar type of activities, confusion is possible. Keeping this in mind, it is advisable that Voluntary Agencies decide their area of work and concentrate on the same with the collaboration of Government.

At Field level, there is necessity for local officers of Health Department to join hands with the Voluntary Organisations and identify the local needs and help the Government.

Lack of thought and concern appears to be evident among people concerned with respect to bannable/ banned drugs. In this situation it is difficult to implement the policy recommendations. But, it has to be done. There is necessity of service mind.

The drug Policy unfortunately is in the hands of the Ministry of Petroleum and Chemicals. There is need for amendments in the same for the good. The State Government intends to communicate to Central Government in this regard.

Benefits are required to reach the rural and marginalised people. The administrative structure needs to be more active.

There are attempts at decentralisation and District Health and Family Welfare Officers are independent to a large extent. Their duties and responsibilities with respect to adminsistartion of Health is to be exercised consciously."

The Hon. Health Minister hoped that the outcome, conclusions and recommendations be supportive to the progress to the Society. He wanted the daliberations of the workship and the recommendations to be sent to the Government. They will receive the earnest cosideration of the Government and implementation to the extent possible.

Dr. T. Ranganatha Achar, Director of Health and Family Welfare Services, Dr. C.R. Krishnamurthy, Addl. Director of Health & Family Welfare Services and Dr. Sona Kalyanpur Rao, Secretary VHAK thanked the Hon. Health Minister.

Preparation of the report of the proceedings :

A Committe of five members was constituted with the responsibility of preparing the final report of this workshop. The draft will be circulated to all the participants, who will be given one month time to respond to the draft. The same committee will then prepare the final draft which will be submitted to Government by August 1992 and copies sent to all members (through the Director of Health Services as there may be transfers). The members of this committee are :

(a)	Dr. C.M. Francis	Director, St. Martha's Hospital, Bangalore.
(b)	Dr.C.R.Krishnamurthy	Addl. Director, Health & F.W. Services Government of Karnataka
(c)	Dr. H. Sudarshan	V G K K, B R Hills, Mysore District, Treasurer, VHAK
(d)	Dr. G.V. Nagaraj	Joint Director, Health & F.W. Services Government of Karnataka
(e)	Dr.S. Pruthvish	Programme Adviser, Disability Division, Action Aid (India) and Member, VHAK.

A Room of My Own

He has gone to his parents' house
and has taken his children.
His flat is quiet.
As I dust his furniture,
As I straighten his books,
the anger grows.
As I sweep his floors,
As I make his beds,
the anger grows.
As I wash his clothes,
As I iron his shirts,
the anger grows.
As I clean his balcony,
As I water his plants,
the anger grows.
He returns to his home laughing.
He has brought along his friends.
"Four teas, please Meera", he shouts to me.
The anger grows.
Then he comes to the kitchen saying "Here, let me help you".
"No!", I bark.
Fangs bared, guarding my domain.
The anger overflows.
"This is my kitchen. I'll do it".
He steps back quickly.
He has been hurt - he doesn't know why.
I've hurt him - I don't know why.
He returns to his friends, hiding his wound.
I retreat into my room, to tend to mine
... and prepare the tea.

—H.K. Rajani

CONCLUSIONS AND MAJOR RECOMMENDATIONS

The Bangalore Workshop on National Health Policy, organised by the

Voluntary Health Association of Karnataka,
Voluntary Health Association of India, and
Directorate of Health & F.W. Services, Government of Karnataka,

with participants drawn form the Government and Voluntary Health Secotrs, meeting at the Institute for Social and Economic Change, Bangalore, on the 9th and 10th April 1991,

Having had the benefit of well searched presentations and papers on

National Health Policy - an overview,
Current Health Status in India,
National Health Policy from the point of view of Government of Karnataka,
National Health Policy as seen by Voluntary Organisations, and
View of Peoples' Repressentatives on National Health Policy,

Taking note of the impact of the New Economic Policy on Health; Deliberating in groups on various issues in Health, especially focussed on

Primary Health Care,
Health Education,
Intersectoral Co-ordination, and
Health Information System,

Reflecting further in the plenary session on the various suggestions and recommendations,

Have come to the following conclusions and major recommendations:

1. Increased Budget Allocation

There is urgent need for increasing the budget allocation for the Health Sector, which is totally inadequate at present. It should be at least 5% of the total budget and progressively increased to 10% by 2000 A.D. Due importance should be given to equitable distribution to rural and urban areas based on population coverage.

Distortions in the allocation of expenditure for preventive, promotive and rehabilitative care on one hand and curative services on the other must be avoided.

Exchange of resources of Government and Voluntary Organisations could avoid duplication and wastage.

2. District Health Policy

Decentralisation of planning, implementation and evaluation of health and health related programmes is necessary. Attempts towards this end by the States through Zilla Parishats were appreciated. There is need to evolve a District Health Policy.

2.(a) The District Health Care progammes will be based on the Karnataka State level health policty to be formulated hereafter, based on the findings, conclusions and recommendations of the workshop.

3. Referral System

A good referral system, utilising and improving the available facilities. Governmental and Voluntary, should be worked out. Proper linkages must be forged between Primary, Secondary and Tertiary levels of health care.

4. National Drug policy

A comprehensive Drug policy should be evolved as part of the National Health Policy.

A list of essential drugs appropriate for each level of use must be prepared. Essential drugs must be made available in adequate quantites and dosage forms for use at all levels of health care. There must be quality assurance of drugs. Adulteration of food and drugs must be prevented.

5.(a) Health Education

Priority must be given to health education. It is necessary to make people health conscious, become aware of health problems and develop attitudes, skills and knowledge to take action for better health. We should enable people to be healthy and maintain the health of individual, family and community. Health Education must be carried out utilising all types of media, as may be appropriate in the given situation.

5.(b) Education of health professionals

The group expressed concern over the increasing numbers of Medical and other health care professionals' colleges. Capitation fee should be abolished.

6. Public Health Act

The existing Public Health Act is no longer relevant. There is need for a new comprehensive Public Health Act, taking into account problems such as environmental pollution.

7. Epidemiologic Unit at District level

There is necessity to establish one epidemiologic unit in each district. All data generated in the Health Information system should focus on giving epidemiological information relevant to the health needs of the people.

Data collection and reporting must be streamlined. They must be communicated in all directions.

8. Mental Health

As part of comprehensive health care, mental health should be given adequate attention, especially community mental health.

Rehabilitation services for the mentally handicapped must be expanded.

9. Political commitment

For action for better health of the people, there is need for political commitment. Without political will, adequate action cannot be taken.

The local and state leaders and elected peoples' representatives must be involved.

10. Training and re-orientation

All persons engaged in health care must be trained for Primary Health Care, Utilising the resources of both government and Voluntary Organisations. The quality of training must be assured.

The health wokers must receive re-orientation from time to time. There is need for continuing education of all health professionals and workers.

11. Adoption of health centres by Voluntary Organisations

Recognised Voluntary Organisations may be encouraged to adopt health centres or sub centres in their totality, with the government placing at their disposal all resources, including manpower, equipment, materials and finances. A list of Voluntary agencies at the local and District level may be prepared.

12. Intersectoral Committees

Intersectoral committees should be formed at different levels to bring about effective co-ordination for better health. These committees should have governmental and non-governmental presonnel involved in health and health related activities including food and agriculture, education, social welfare, engineering, water and sanitation, animal husbandry and others.

The committees may be formed at various levels - Village, block, district and state - with appropriate membership.

13. Indigenous systems of Medicine

Indigenous systems of medicine must be promoted. They must be available to people to choose according to their wish. They must be integrated with the health system to the extent possible.

14. Improving existing system

Existing health care systems must be strengthened before expanding the services.

15. Occupational Health

Greater attention must be paid to occupational health and diseases associated with occupations, whether agricultural, industrial or otherwise.

There should be co-ordinated activities with the department of labour.

WORKSHOP ON "NATIONAL HEALTH POLICY"

Organised By VHAK, VHAI And Directorate Of Health And Family Welfare Services, Government Of Karnataka At ISEC, Bangalore on 9th And 10th April 1992.

Working Group

1.	Dr. C.M. Francis	: Director, St. Martha's Hospital, Bangalore.
2.	Sr. S.V. Rama Rao	: Rtd. Director of Rural Health Services and Training Programmes, St. John's Medical College, Bangalore.
3.	Dr. H. Sudarshan	: V G K K, B.R. Hills, Mysore district
4.	Dr. (Mrs) Sona Kalyanpur Rao	: Medical Officer and Co-ordinator, Holdsworth Memorial Hospital, Mysore.
5.	Dr. Dara S. Amar	: Prof. and HOD, Community Health Dept., St. John's Medical College, Bangalore.
6.	Dr. S.P. Tekur	: Community Health Cell, Bangalore
7.	Dr. S. Pruthvish	: Programme Adviser, (Disability) Action Aid India, Bangalore

Resource Group

1.	Dr. C.R. Krishnamurthy	: Addl. Director, Health & F.W. Services Government of Karnataka, Bangalore
2.	Dr. C. Prasanna Kumar	: Rtd. Director, Health & F.W. Services Government of Karnataka, Bangalore.
3.	Dr. Patil Kulkarni	: Rtd. Chief Health Officer, Corporation of the City of Bangalore.
4.	Dr. (Mrs) M.K. Vasundhara	: Prof. & HOD, Dept. of Community Medicine, Govt. Medical College, Bangalore.
5.	Dr. G. Rangaswamy	: Deputy Director (Family Welfare) Health & F.W. Services, Government of Karnataka, Bangalore.
6.	Dr. M.K. Kulkarni	: Prof. & HOD, Dept. of Community Medicine, Govt. Medical College, Mysore.
7.	Sri. S.M. Subramanya Setty	: Asst. Professor, Dept, of Health Education, NIMHANS, Bangalore.

Workshop Secretariat

1.	Miss. T. Neerajakshi	: Promotional Secretary
2.	Mr. Ramappa C. Hadil	: Programme Co-ordinator
3.	Mrs. Indira I.L	: Typist
4.	Mr. Shivaraju D.N.	: Office Assistant

VOLUNTARY HEALTH ASSOCIATION OF KARNATAKA

The need for a state level apex organisation in the Voluntary Health Sector based on secular principles was fulfilled in the formation of Voluntary Health Association of Karnataka in the year 1974, based in Bangalore. The VHAK starting initially with 25 institutions has grown into a big institution with a membership strength of 150 institutions spread all over Karnataka.

VHAK brings together the Voluntary Organisations both in health and Non-health areas and Government agencies to thrash out better collaborative mechanisms and co-operation among them for a unified comprehensive development of the State.

Membership is open to all Health and Development Organisations (having Health as one of their components) which are registered under the Societies' Act or any other Act. The Organisations should be non-profit making and non-sectarian in their approach.

Highlights of its approach include:

- Helping to create the atmosphere for building up a peoples' Health movement
- To act as a liason between voluntary institutions and government agencies
- To help in co-ordination of Health care activities in voluntary sector
- To help member institutions in organising trainig programmes, seminars, workship, etc.,
- Information dissemination and networking
- Studying, documenting and promting alternative systems of Medicine and
- To mobilise the resources of both Government and Voluntary sector.

Further Details on VHAK can be had from:
Voluntary Health Association of Karnataka
No. 60, Rajini Nilaya
Ramakrishna Mutt Road Cross
Ulsoor, Bangalore - 560 008.
Telephone No. 576606

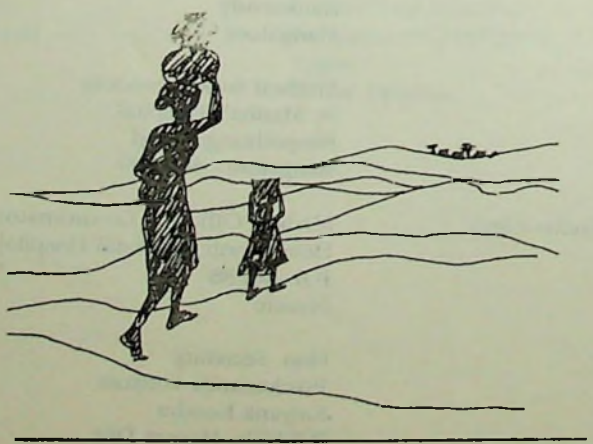
EXECUTIVE BOARD OF VHAK

• Fr. Bernard Moras President	Director Fr. Muyller's Hospital Kankanady Mangalore
• Dr. Sr. Teresita Vice-President	Medical Superintendent St. Martha's Hospital Nrupathunga Road Bangalore - 560 009
• Dr. (Mrs) Sona Kalyanpur Rao Hon. Secretary	Medical Officer & Co-ordinator Holdsworth Memorial Hospital P.B. No. 38 Mysore
• Dr. H. Sudarshan	Hon. Secretary Vivekananda Girijana Kalyana Kendra B.R.Hills, Mysore Dist.

•	Dr. B.D.R.Paul	Director Holdsworth Memorial Hospital P.B.No. 38 Mysore
•	Dr. Dara S. Amar	Prof. & Head, Community Health Department St. John's Medical College Sarjapur Road Bangalore - 34
•	Mr. Premananda Thambi	Co-ordinator S I B S Bangarpet, Kolar Dist.
•	Dr. Upendra Shenoy	Arogya Vikasa Information Resource Centre K.G. Nagar Bangalore.
•	Dr. S. Pruthvish	Programme Adviser Disability Division Action Aid, India Bangalore.

OFFICE STAFF OF VHAK

Miss. T. Neerajakshi
Promotional Secretary
Mr. Ramappa C. Hadli
Programme co-ordinator.



VOLUNTARY HEALTH ASSOCIATION OF INDIA

The need for a national apex organisation in the Voluntary Health sector based on secular principles was strongly expressed in a meeting of leaders of Voluntary Hospitals and Health care Institutions in India in a meeting held in Bangalore in 1969. This started a process which culminated in the formation of Voluntary Helath Association of India in 1974 based in Delhi with a clear mandate to promote the concept of Community Health in the country in order to correct the prevailing imbalances in the Health care delivery system due to our emphasis on expensive Hospital oriented curative Health services. In its 15 years of existance VHAI has established links with more than 3000 health and Development organisations spread all over the country.

V H A I works to promote Social Justice in the provision and distribution of Health. Its major activities are aimed at achieving the following objectives :

- Helping to create the atmosphere for building up a peoples' Health movement through effective networking, lobbying, campaigning and public affairs related activities.
- Helping in the evolution of low cost, appropriate and people oriented health programmes in harmony with the traditional knowledge and skills of the community.
- Providing support services to Community Health programmes taken up by members and Associates.

These activities are carried out by the various divisions of VHAI, viz

TRAINING
COMMUNICATIONS
PUBLIC POLICY
PUBLIC AFFAIRS

STATE VHAs

VHAI is a federation of 19 state level Voluntary Health Associations. Membership of VHAI is thorugh State VHAs and is availbel to all health and development institutions and programmes run on a no-profit basis irrespective religion, caste or creed. VHAI collaborates with State VHAs on areas of common concern while supporing them in their infrastructural and planning activities. While initiating the formation of new VHAs, VHAI is also involved in the revamping of some existing ones.

Further details on VHAI can be had from :

Voluntary Health Association Of India
No. 40, Institutional Area (Near Qutab Hotel)
New Delhi - 110 016
Telephone : 668071, 668072, 665018, 655871, 652952

ACKNOWLEDGEMENT

- *Dr. A K M Naik* Secretary - II,
  Department of Health & Family Welfare Services, Government of Karnataka.
- *Dr. T. Ranganatha Achar* Director, Health & Family Welfare Serivces, Government of Karnataka
- *Dr. C.R. Krishnamurthy* Addl. Director, Health & Family Welfare Services, Government of Karnataka
- *Sri. T.R. Satish Chandran* Director, Institute for Social and Economic Change, Bangalore.
- *Dr. C.M. Francis* Director, St. Martha's Hospital, Bangalore.
- All Members of the working Groups, Resource Persons, Resource Group and Participants.
- VHAI, New Delhi for financial support.

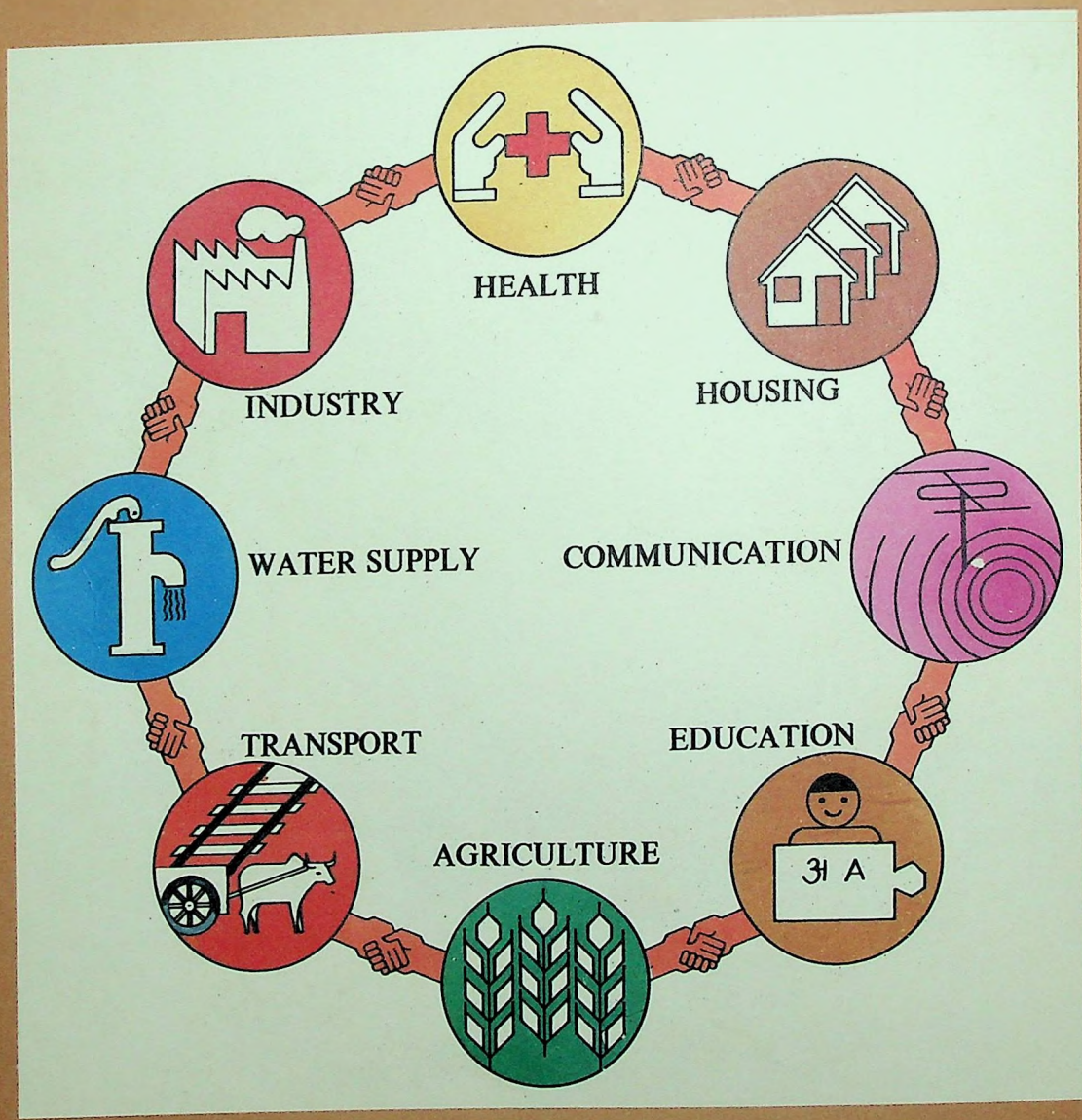
The Voluntary Health Association of India (VHAI) is a non-profit registered society formed by the federation of Voluntary Health Associations organised at the level of States and Union Territories. VHAI links over 3000 grassroots-level organisations and community health programmes spread across the country.

VHAI's primary objectives are to promote community health, social justice and human rights related to the provision and distribution of health services in India.

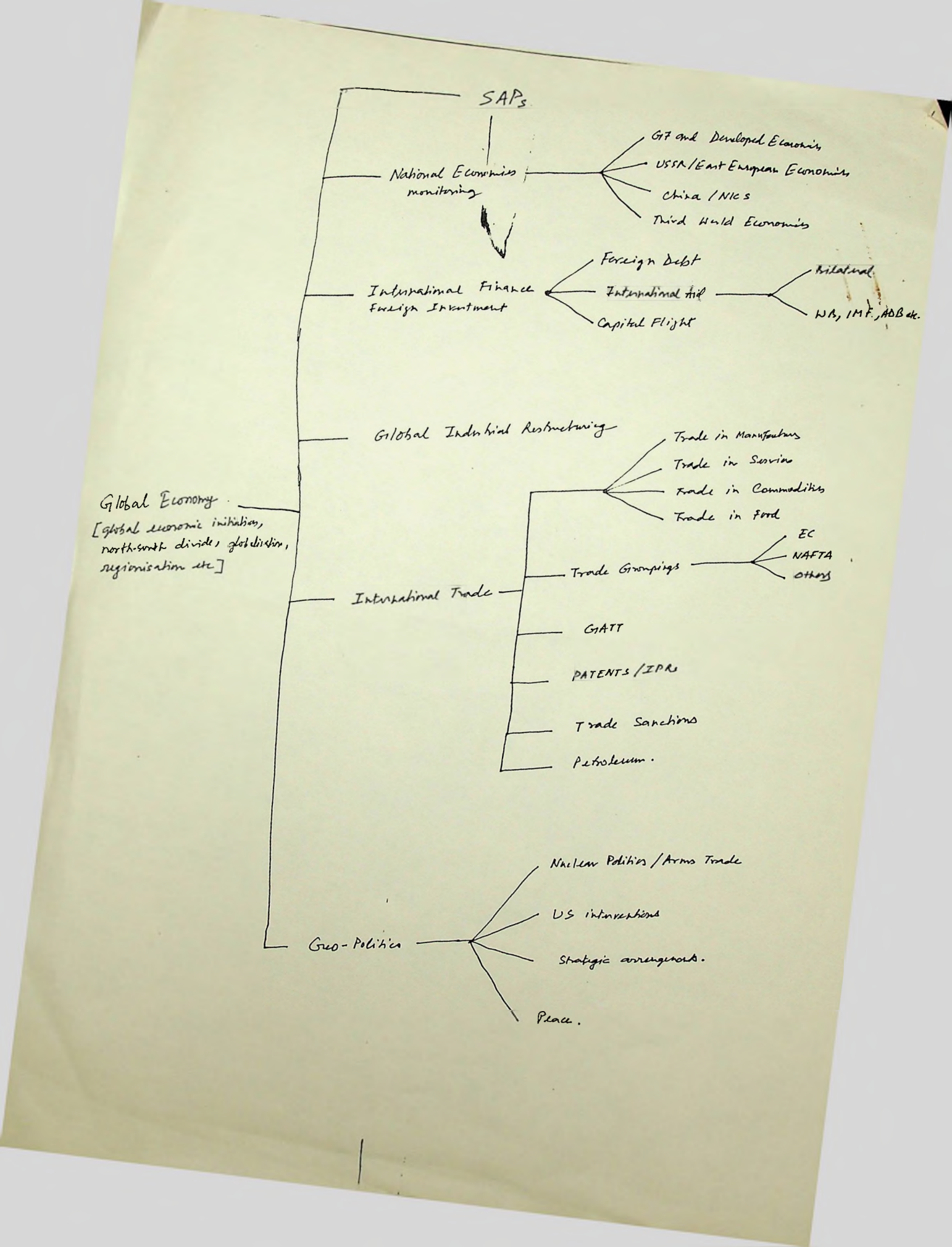
VHAI fulfils these objectives through campaigning, policy research, and press and parliament advocacy; through need-based training and provision of information and documentation services; and through production and distribution of innovative health education materials and packages, in the form of print and audio-visuals, for a wide spectrum of users — both urban and rural.

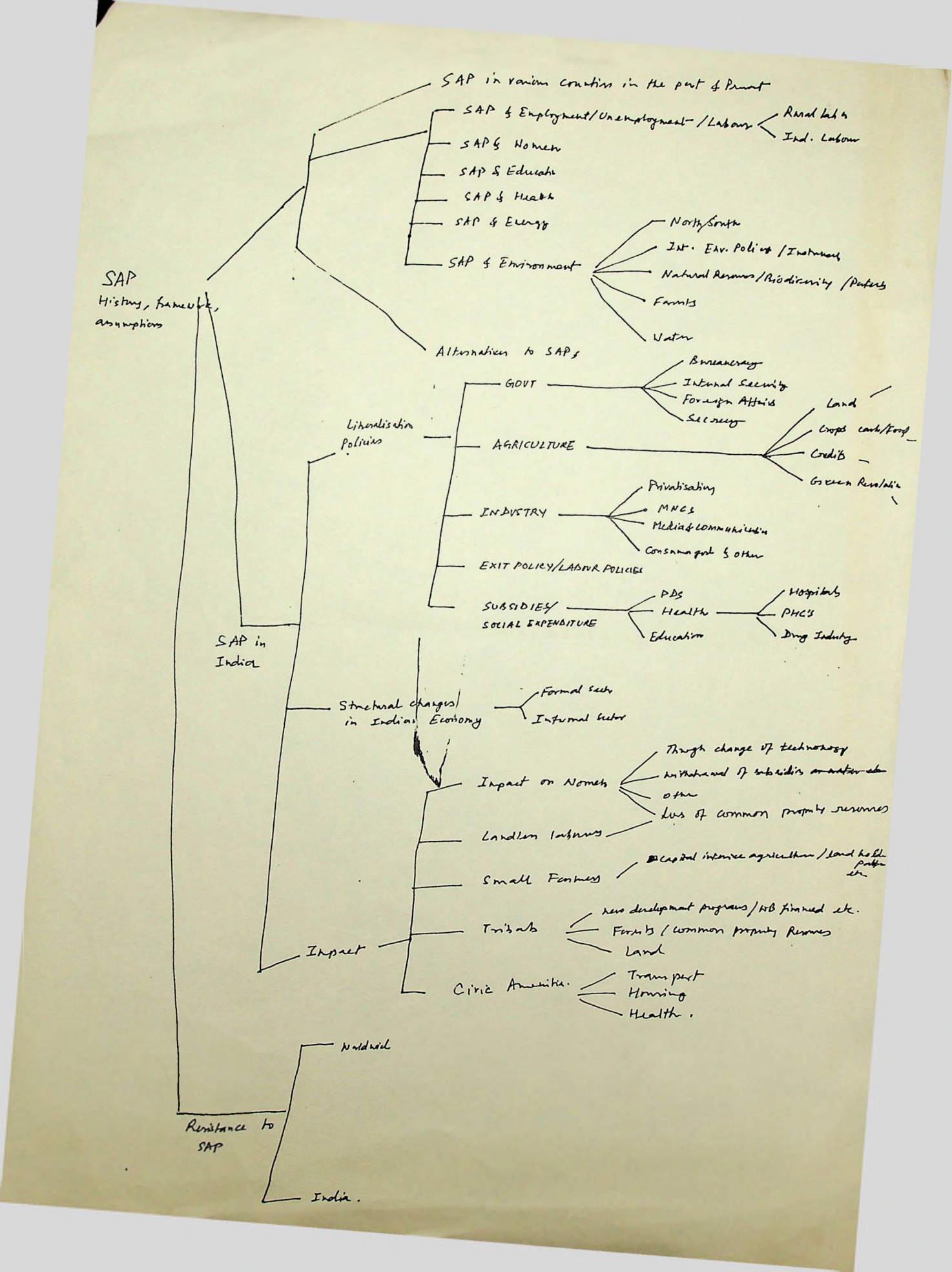
VHAI tries to ensure that a people-oriented health policy is formulated and effectively implemented. It also endeavours to sensitise the larger public towards a scientific attitude to health, without ignoring India's natural traditions and resources.

Intersectoral Cooperation



This is a MUST to achieve Health for all by 2000 AD.


Global Economy
[global economic initiatives, north-south divide, globalisation, regionalisation etc]
SAPs
National Economies monitoring
G7 and Developed Economies
USSR/East European Economies
China / NICs
Third World Economies
International Finance Foreign Investment
Foreign Debt
International Aid
Capital Flight
Bilateral
WB, IMF, ADB etc.
Global Industrial Restructuring
International Trade
Trade in Manufactures
Trade in Services
Trade in Commodities
Trade in Ford
Trade Groupings
EC
NAFTA
others
GATT
PATENTS / IPRs
Trade Sanctions
Petroleum.
Geo-Politics
Nuclear Politics / Arms Trade
US interventions
Strategic arrangements.
Peace.


SAP in various countries in the past & Present
SAP & Employment/Unemployment/Labour
Rural labour
Ind. Labour
SAP & Women
SAP & Education
SAP & Health
SAP & Energy
SAP & Environment
North/South
Int. Env. Policy/Instrument
Natural Resources/Biodiversity/Patents
Forests
Water
SAP
History, framework, assumptions
Alternatives to SAPs
Liberalisation Policies
GOVT
Bureaucracy
Internal Security
Foreign Affairs
Secrecy
AGRICULTURE
Land
Crops cash/food
Credit
Green Revolution
INDUSTRY
Privatisation
MNCs
Media & Communication
Consumerism & other
EXIT POLICY/LABOUR POLICIES
SUBSIDIES/ SOCIAL EXPENDITURE
PDS
Health
Education
Hospitals
PHC's
Drug Industry
SAP in India
Structural changes in Indian Economy
Formal Sector
Informal Sector
Impact
Impact on Women
Through change of technology
Withdrawal of subsidies
other
loss of common property resources
Landless labourers
Small Farmers
Capital intensive agriculture/land holding pattern etc
Tribals
New development projects/WB financed etc.
Forests/common property Resources
Land
Civic Amenities
Transport
Housing
Health.
Resistance to SAP
World wide
India.

04 May '94

Dr. CM Francis VHAK.
Dr. G.V. Nagaraj GOK.
Dr. Shanmughams. (copy to VHAK for transmission).

Dear . . .

Greetings from CHC!

Enclosed, please find the first draft of available statistics to help in compilation of information on the Health Services and Systems of Karnataka.

(1) This does not include the write-up on Voluntary organisations, etc. in Karnataka, which is under preparation and will be sent to you later

(2) It is compiled from available statistics (Sources indicated)

We need the following to make it complete

(1) Latest statistics if available with you.
(2) District-wise analysis of statistics - if available.
(3) History of Karnataka's Health services.
(4) Statistics on National programs and their implementation.
(5) Morbidity profiles - if available - districtwise.
(6) Information from any other relevant surveys/statistics if available with you.
(7) Public Health measures taken in Karnataka including Research/ vaccine development, etc
(8) Latest material on Handigodu Syndrome & K.F.D.

You could update this and send it to VHAK, or pass on any reference material you feel will update it adequately - which I can do.

With Regards and Best Wishes, Yours sincerely,

Soil (1)

STATE OF KARNATAKA'S HEALTH

HEALTH SYSTEMS AND SERVICES

Introduction:

Karnataka is the eighth largest state in India in terms of land area and population. It is located in the mid and southern peninsular part of the subcontinent, extending from the Western coastline, across the Western ghats to the Deccan plateau in the mid-portion of the peninsula.

Karnataka ~~[illegible]~~ surrounds Goa on the western coast, and ~~it~~ has Maharashtra in the north and Kerala in the south along the coast. Andhra Pradesh and Tamilnadu border it on the East and south-east.

Karnataka's Health Systems and Services need to be considered not only on their own, but also in relation to these neighbouring states that share its boundaries along with people and problems which are contiguous. ~~[illegible]~~. Also, such a comparison would put in context any understanding of health ~~[illegible]~~ in relative terms considering the better health status of the southern parts of ~~the~~ our country.

Historically, Karnataka's Health systems and services evolved from an amalgamation of the different geographical areas and their services following ~~[illegible]~~ the re-organisation of States after India's Independence. Karnataka includes areas from the erstwhile Mysore state and adjacent Malabar areas along the west coast, parts of Bombay and

Madras presidencies, and the Hyderabad-Karnatak areas from the Nizam's dominion prior to reorganisation.

(Refer Box for History of Karnataka's Health Services)

~~Factors affecting Health:~~

Karnataka and its people suffer from most of the diseases in the country. In addition, Handigodu Syndrome and Kyasanur Forest disease are peculiar to this State.

(Refer Boxes for H.S. & K.F.D.)

Factors affecting Health:

Some factors which are universally accepted as affecting Health of people are reiterated below to establish the setting in which Karnataka's Health systems and services operate. A comparison with the neighbouring states and national figures clarifies Karnataka's position better. These include, Population density, ~~Sex proportion~~, Decadal growth rates, sex-ratio, literacy rates esp. especially female literacy, population ~~under~~ below the poverty line, ~~rural~~ ~~population~~ of urbanisation and road communication to villages and some trends which have an impact on health. It provides the setting, and milieu in which ~~these~~ the Health care services and systems operate.

STATE	Ranking by popnly	Population density		Decadal growth rate		Sex ratio		Literacy	
		1981	1991	'71-'81	'81-'91	1981	1991	Total	Female
Karnataka	8	194	234	+26	+20	975	972	55·9	44·3
Andhra Pradesh	5	195	241	+23	+23	963	960	45·1	33·7
Kerala	12	655	747	+19	+13	1032	1040	90·5	86·9
Maharashtra	3	204	256	+24	+25	937	936	63·0	53·5
Tamil Nadu	7	372	428	+17	+14	977	972	63·7	52·3
India	—	216	267	+24	+23	934	929	42·9	32·5

Source #1

Karnataka is less dense in population than its neighbours with a fast declining decadal growth rate matched only by densely populated Kerala.

The sex ratio in Karnataka is adverse, and worsening, with only Kerala which shows positive improvement. Maharashtra shows a lesser decline.

Karnataka is better only than Andhra Pradesh in total and female literacy and far behind other neighbours, especially Kerala.

Karnataka is better than countrywide figures on all counts.

How closely related are Female literacy and an adverse & worsening sex ratio as opposed to an improving one is evident from the list below. Also, the regional differences within Karnataka itself in both these aspects is evident.

Districts with worsening Gender (Sex) ratio and Female literacy levels.

District	Females per 1000 males		Female Literacy levels (%)	
	1981	1991	Rural	Urban
Bellary	973	957	19.50%	42.13
Bidar	968	953	19.66	46.48
Bijapur	982	965	29.58	46.70
Gulbarga	981	962	12.94	43.05
Kolar	871	962	29.56	56.74
Raichur	988	978	13.16	35.79

Source #2 These districts are from Hyderabad-Karnatak area adjacent to A.P.

Districts with improving Sex ratios & Female literacy

District	Females per 1000 males		Female Literacy levels (%)	
	1981	1991	Rural	Urban
Chickmagalur	953	977	40.39	62.13
Kodagu	933	989	49.98	67.05
D. Kannada	1059	1063	55.45	68.84
Hassan	987	1000	33.83	65.62
Shimoga	947	961	37.16	61.86
U. Kannada	958	967	43.27	63.42

Source #2 These districts belong to the 'Malnad' area along the coast and Western Ghats.

	IND	KAR	AP	KER	MAH	T.N.
Ratio of urban (1991) population to total %	25.7	30.9	26.8	26.4	38.7	34.2
Increase (%) urban during 1951 - 1991	36.2	29.1	42.6	60.9	38.7	19.3
Population below poverty line 1987-88 (as % of total)	29.9	32.1	31.7	17.0	29.2	32.8
% Villages (1987-88) Connected by fairweather roads	40.7	32.9	43.0	100	52.9	63.2

[Source #3]

Karnataka is less urbanised than Gujarat, Maharashtra and Tamilnadu; with an increase in the past decade less than both all the states in the country, except Tamilnadu.

Almost a third of Karnadigas live below the poverty line, matched only by Tamilnadu.

Karnataka is less well connected by fairweather roads (only 1/3rd), compared to all neighbours, and even by national standards.

Despite a slower rate of urbanisation overall, a few centres in Karnataka are growing very rapidly. (and hence tend to concentrate the medical services available.) as seen in the table below

Place	Population ('000s)	Decennial growth rate
Bangalore	4,087	39.9%
Belgaum	402	33.7%
Hubli - Dharwad	648	22.9%
Mangalore	426	39.1%
Mysore	652	36.2%

Source # 3

Vital Statistics and trends :

Source #4.

			Karnataka	India
1.	Expectation of life at birth (in years) (1991-96 - Projected)	Male	64.15	60.6
		Female	65.30	61.7
2.	FERTILITY			
	a) Birth rates	Rural	28.8	31.5
		Urban	24.8	24.4
		Combined	27.8	29.9
	b) Total Fertility Rates	Rural	3.7	4.5
		Urban	2.9	3.1
		Combined	3.5	4.2
	c) Gross Reproduction Rate	Rural	2.1	2.2
		Urban	1.6	1.5
		Combined	2.0	2.0
3.	MORTALITY			
	a) Death rate	Rural	8.8	10.4
		Urban	6.1	6.7
		Combined	8.1	9.6
	b) Infant Mortality Rate	Rural	81	86
		Urban	39	51
		Combined	71	80
	c) Neonatal and Postnatal Mortality Rates	Neonatal	54.4	59.8
		Postneonatal	18.8	36.6
		Combined		

While there is a gradual declining trend in the Birth and Death rates in Karnataka between 1986 to 1989, ~~Bearing to National figures~~, a comparison with similar figures of surrounding states is useful.

Source #5

Comparative table of Birth rates in 1986 and 1989.

Year	India	Kar	A.P.	Kerala	Maha	T.N.
Combined						
1986	32.6	29.0	31.6	22.5	30.1	23.8
1989	30.5 2.1	27.9 1.1	25.6 6	19.8 2.7	28.3 1.8	23.1 0.7
Rural						
1986	34.2	29.9	32.4	22.4	31.7	24.1
1989	32.0 2.2	28.9 1	26.0 6.4	19.7 2.7	30.4 1.3	23.5 0.6
Urban						
1986	27.1	26.8	28.7	23.0	27.4	23.1
1989	25.0 2.1	25.0 1.8	24.1 4.6	20.2 2.8	24.4 3	22.2 .9

The decline in Birth rates is lesser than in neighbouring states and national figures, except for Tamilnadu, which has a lower birth rate as such. This is both for urban and rural areas, with the latter showing a lesser decline. Neighbouring Andhra Pradesh shows more dramatic fall in birth rates in urban and rural areas. The urban birth rates are the highest in 1989, on par with national figures.

Comparative table of Death rates 1986 and 1989.

Source #5

Year	India	Kar	A.P.	Kerala	Maha	T.N.
Combined						
1986	11·1	8·7	9·9	6·1	8·4	9·5
1989	10·2	8·7	9·3	5·9	7·9	8·6
Rural						
1986	12·2	9·4	10·7	6·0	9·7	10·7
1989	11·1	9·5	10·0	5·9	8·9	9·7
Urban						
1986	7·6	6·8	7·1	6·9	6·1	7·1
1989	7·1	6·5	6·5	6·0	6·1	6·6

In comparison, the death rates in Karnataka have not fallen as much as our neighbours, or even national averages. The rural areas have a worsening situation.

Comparative table of IMRs (1989)

Source #5

	India	Kar	A.P.	Kerala	Maha	T.N.
Combined	91	80	81	22	59	68
Rural	98	89	87	23	66	80
Urban	58	53	53	15	44	43

The IMR in Karnataka is below national average and comparable to Andhra Pradesh. The rest of our neighbours have less infant mortality.

6

No. of ~~Hospitals~~ Doctors and average population served (1990)
(Source #5)

	Kar	A.P.	Kerala	Maha	T.N.
Total Doctors	31,028	33,283	4,163	62,770	48,291
Pop. served per Dr.	1:1457	1:1924	1:7213	1:1179	1:1165
Data relates to	31/12/90	31/12/90	31/12/90	31/12/89	31/12/90.

Each of our doctors serves a larger population than in Maharashtra and TN., and less than in Kerala and A.P.

No. of Hospitals and beds as on 1/1/1991 according to Rural/Urban areas.
(Source #5)

		Kar	A.P.	Kerala	Maha 1/1/90	T.N. 1/1/90
Hospitals	Rural	25	165	2328	345	89
	Urban	263	450	596	1759	319
	Total	288	615	2924	2104	408
Beds	Rural	2,526	5,716	37,859	12,120	4,235
	Urban	31,951	32,684	32,490	99,300	44,545
	Total	34,477	36,400	70,349	1,11,420	48,780.

Karnataka has less number of hospitals, especially in the rural areas than any of its neighbouring states.

No. of Dispensaries and beds according to Rural / Urban as on 1/1/91

Source #5

		Kar	A.P.	Kerala	Maha 1/1/90	T.N. 1/1/90
Dispensaries	Rural	610	549	1243	796	147
	Urban	232	244	509	8,406	365
	Total	842	793	1752	9,202	512
Beds	Rural	355	171	95	452	138
	Urban	242	106	64	1,966	140
	Total	597	277	159	2,418	278.

Karnataka's rural areas are better served in terms of Dispensaries and beds than its neighbours AP & TN. ~~Heatres~~ We do not match with Kerala in terms of dispensaries, while Maharashtra is better, with a predominance of urban services.

No. of Hospitals and Beds according to ownership - 1/1/91

Source #5

		Kar	A.P.	Kerala	Maha 1/1/90	TN 1/1/90
HOSPITALS	GOVT	209	345	137	693	282
	Local bodies	28	04	0	92	07
	Pvt & Volag	51	266	2787	1319	119
	TOTAL	288	615	2924	2104	408
BEDS	GOVT.	26,424	25,251	26,474	62,684	37,935
	Local bodies	~~25,~~ 714	46	0	10,955	479
	Pvt & Volag	7339	11,103	43,875	37,781	10,366
	TOTAL	34,477	36,400	70,349	111,420	48,780
Popln. served per	Hospital	157,000	95,416	10,269	35,184	136,159
	Bed.	1,311	1,612	427	664	1,139.

Karnataka has the least number of Govt. Hospitals (except Kerala) among the southern states. The bed strength is comparable to Kerala and A.P., but less than Maha & TN.

Local bodies running hospitals and their beds are much better in Karnataka than neighbouring states, except Maharashtra, which is very much ahead.

We have least number of voluntary agencies and Private hospitals/beds compared to neighbouring states.

The population served per hospital is the maximum in Karnataka, while a higher bed strength makes the population per bed ratio better than A.P.

Establishment of PHCs, Sub-centres and Community Health Centres — progress between 1985 to 1990.
as on 1/4/1990.

Source #5

No. functioning	As of	Kar.	A.P.	Kerala	Maha	T.N.
Primary Health Centres	1/4/85	365	555	199	1,539	436
	1/4/90	1,133	1,283	886	1,646	1,386
Sub-centres	1/4/85	4,964	6,129	2,270	6,391	5,860
	1/4/90	7,793	7,894	5,094	9,248	8,681
Community Health Centres	1/4/85	98	27	04	147	30
	1/4/90	146	46	54	283	72

The progress is comparable to neighbouring states. Maharashtra remains ahead, with a better coverage since the beginning of this six year period.

Communicable disease being a major cause of morbidity and mortality, the ability of the medical/health services considered so far to tackle these is important.

Reported cases and deaths due to Communicable disease during 1990. (Cases & deaths)

Source #5

Disease	Karnat.		A.P.		Kerala		Maha		T.N.	
	Cases	Deaths	Cases	D	Cases	D	Cases	D	Cases	D
Diphtheria	460	7	1515	24	66	4	219	11	22	1
Polio	204	8	1987	23	68	1	413	11	730	4
Tetanus (neonatal)	393	54	814	61	41	8	259	65	102	25
Tetanus (others)	499	104	1081	123	37	11	968	167	473	54
Whooping Cough	3,906	1	11,966	17	3,648	3	257	0	311	0
Measles	2,230	3	6,377	36	13,400	4	2,110	3	9,818	74
A.R.I.	423,803	186	864,618	253	1,894,188	98	276,790	54	163,400	157
Pneumonia	4,369	59	20,923	105	8,661	33	5,745	253	7,359	17
Enteric Fever	8,062	15	48,019	46	6,092	9	8,368	55	11,500	34
Viral Hepatitis	2,441	89	15,433	120	9,010	16	10,750	510	232	3
Rabies	1345	40	680	91	469	33	96	80	255	18
Syphilis	7,439	2	20,465	3	480	0	3,066	0	2,271	0
Gonococcal Infect.	8,085	6	59,939	20	2,017	0	1,986	0	1,753	36
Tuberculosis	79,459	821	216,192	1250	49,288	236	79,363	905	75,796	649
Guinea worm	634	NA	224	NA	NA	NA	209	NA	0	0

Among the vaccine preventable diseases, Karnataka fares better than its neighbours, except Kerala which reports a higher incidence of measles and comparable in Whooping cough. ARI and Pneumonia taken together show greater mortality for Maharashtra & AP. Enteric fever ~~is~~ in Kerala

Among the vaccine preventable diseases under U.I.P., we have the least problem of Measles, and comparatively ~~much~~ better off than only Andhra Pradesh. Maharashtra is worse off in mortality due to Diphtheria and Neonatal tetanus. Morbidity due to polio is ~~better than~~ more than in Kerala and mortality more than in Kerala and Tamilnadu

In Respiratory infections, (ARI and Pneumonias) we have lesser morbidity than A.P. and Kerala while ~~morbi~~ mortality is lesser than in Maharashtra and A.P.

In Gastro-intestinal infections (Enteric Fever & Viral Hepatitis) we have least morbidity, but greater mortality than TN and Kerala.

We have the highest mordity due to Rabies, but lesser mortality than in A.P. and Maharashtra.

Among sexually transmitted diseases like Syphilis and Gonococcal infections, we have lesser morbidity than only A.P. The mortality for Gonococcal infections is reported much higher in Tamilnadu.

The morbidity in Tuberculosis is comparable to TN and Maharashtra, though lesser than in A.P. The mortality is lesser than in A.P. and Maharashtra.

Karnataka has the highest ~~incidence~~ morbidity due to Guineaworm infection with A.P and Maharashtra reporting only a third of cases each and Kerala & TN not reporting this problem at all.

Data from 'SURVEY OF CAUSES OF DEATH (rural)

The Office of the Registrar General of India has evolved a process of collecting reliable mortality data from rural areas all over the country, started as the 'Model Registration Scheme' in the sixties and renamed as 'Survey of causes of death (rural)', since 1982.

Karnataka has participated in this process since 1967, with the Bureau of Economics and Statistics as the implementing agency. The Southern States have provided more than 95% returns. Karnataka has provided 100% reports from 52 sample PHCs out of 1133 (30/6/90) during 1990 ~~&~~ and 1991, reporting 872 and 916 deaths in these areas during 1990 and 1991 respectively.

Death being a definitive event vis-a-vis morbidity, an analysis of these data and in comparison with our neighbouring states will be a revealing exercise to understand the State's health profile.

Percentage distribution of deaths by major cause groups

Source #6

Cause	India	Kar	A.P.	Kerala	Mah	T.N.
1. Senility	23.8	25.3	22.1	7.2	31.3	20.9
2. Coughs	18.9	19.7	16.3	17.3	17.7	13.1
3. Diseases of Circulatory system	11.1	12.3	12.3	22.1	8.8	21.2
4. Causes peculiar to Infancy	10.2	11.2	9.8	4.2	13.3	7.1
5. Accidents & injuries	8.5	6.5	9.5	11.4	9.2	7.7
6. Other Clear symptoms	8.3	10.6	10.1	12.8	8.8	9.6
7. Fevers	7.3	3.7	4.9	0.6	2.6	6.0
8. Digestive Disorders	6.4	5.0	6.4	9.2	3.3	6.9
9. Disorders of CNS	4.4	5.4	7.7	14.6	3.9	7.0
10. Child birth & pregnancy	1.1	0.3	0.9	0.6	1.1	0.5
	100.50	100	100.0	100	100	100

Deaths due to 'senility' — where an individual is over sixty years of age with no apparent sickness otherwise in the list — account for a quarter of deaths in Karnataka, next only to Maharashtra, and above national figures.

The percentage of deaths due to 'coughs' is maximum in Karnataka, compared to other states and national figures.

A less percentage of people die in Karnataka due to circulatory diseases than in Kerala and TN. It is equal to A.P. percentages, but higher than national figures.

'Causes peculiar to infancy' account for more deaths than Karnataka's neighbours and Indian averages, except Maharashtra.

'Accidents and injuries' cause the least percent of deaths in Karnataka, even below national figures.

~~'Digestive disorders' caused~~ "Other clear symptoms" are recorded less than only Kerala.

'Fevers' account for lesser deaths than in AP & TN.

'Digestive disorders' are the least, except Maharashtra.

'Diseases of CNS' account for more deaths than Maharashtra and national average, and lesser than other neighbours.

'Child births & pregnancy' account for the least percentage of deaths.

An analysis of the classification of the causes of death from the above listing makes clear the reasons for mortality, as in the next table.

Percentage distribution of deaths under the cause group of 'Coughs' (1951)

(Source #6)

Cause	India	Kar	A.P.	Kerala	Maha	T.N.
1. Asthma & Bronchitis	43·5	58·9	49·8	72·0	41·5	58·4
2. T.B. of lungs	28·1	29·4	43·9	19·5	24·5	35·1
3. Pneumonias	24·6	8·9	1·8	3·7	31·6	5·4
4. Whooping Coughs	1·0	1·1	0·4	0·0	0·0	0·0
5. Not classifiable	2·7	1·7	4·2	4·9	2·4	1·0

1. Asthma & Bronchitis take a high toll, lesser than only Kerala, and comparable with A.P. All Southern states except Maharashtra show a higher than National figures
2. T.B. of lungs is higher than national figures, though less than in AP & TN.
3. Pneumonias is more than in AP, Kerala and TN - less than in Maharashtra and much below national figures.
4. Whooping cough deaths still occur in Karnataka and A.P.!
5. The "not-classifiable" coughs are least, except in TN

Percentage distribution of deaths under 'Diseases of Circulatory system' – 1991

[Source #6]

Cause	India	Kar	A.P.	Kerala	Maha	T.N.
1. Heart attack	52.2	58.4	64.4	75.8	52.0	62.7
2. Anaemia	26.9	30.1	13.4	6.7	16.7	16.4
3. Other Heart Diseases	20.9	11.5	22.2	18.8	31.3	20.9

'Heart attacks' take a big toll, though lesser than in Kerala, AP & TN. and above National & Maharashtra figures

More people die of Anaemia by percentage, compared to all neighbours and even above national averages.

'Other Heart Diseases' have a lesser percentage of toll.

Percentage distribution of infant deaths – 1991

[Source #6]

Cause	India	Kar.	A.P.	Kerala	Maha	TN
1. Causes peculiar to infancy	68.0	76.9	100.0	–	80.6	85.8
2. Coughs	15.0	6.0	0.0	–	14.9	6.3
3. Fevers	5.4	6.7	–	–	0.3	2.4
4. Digestive disorders	3.5	3.0	–	–	0.9	1.6
5. Diseases of Circulatory system	3.0	2.2	–	–	0.3	1.6
6. Other clear symptoms	2.4	2.2	–	–	–	–
7. Disorders of CNS	1.6	0.7	–	–	2.0	0.8
8. Accidents & injuries	1.1	2.2	–	–	1.1	1.6

Fevers, and Accidents & injuries take a larger percentage of deaths compared to Karnataka's neighbours. 'Causes peculiar to infancy' takes a larger toll than national averages, though less than neighbouring states.

Percentage distribution of deaths in 'Causes peculiar to infancy'.

Source #6

Cause	~~India~~ India	Kar	A.P.	Mahar	T.N.
1. Prematurity	48.2	41.7	32.0	73.4	28.4
2. Respiratory infection of Newborn	15.4	24.3	15.7	6.4	48.6
3. Diarrhoea of Newborn	6.8	9.7	7.0	0.5	9.2
4. Cord infection (including tetanus)	5.0	3.9	2.3	0.5	19.8
5. Congenital malformation	4.3	1.9	2.3	2.5	4.6
6. Birth injury	1.3	2.9	0.0	0.0	2.6
7. Not classifiable	18.9	15.5	40.7	16.8	4.6

During infancy ~~more~~ more children die in Karnataka due to 'Prematurity' - less than national and Maharashtra figures
- Respiratory infections take the next largest toll, less than in TN.
- Diarrhoeas account for ~~the most~~ more deaths in comparison to all neighbours and All India figures. So, does ~~Cord~~ 'Birth injuries'.
- 'Cord infections' in Karnataka is less than All-India & TN.
- 'Congenital malformation' deaths are the least in Karnataka.
- 'Not classifiable' diseases are below all figures, except TN.

Percentage distribution of deaths under 'Accidents or Injuries' 1991

Source #6

Cause	India	Karn	A.P.	Ker	Maha	TN
1. Vehicular Accidents	22.6	8.5	14.4	24.1	25.0	18.5
2. Suicides	16.6	32.2	27.5	53.7	9.5	52.1
3. Burns	14.1	6.8	13.2	0.0	32.7	1.7
4. Drowning	11.6	22.0	14.4	11.1	14.5	6.7
5. Snake bite	7.5	6.8	7.2	5.6	4.5	8.4
6. Natural Calamity	5.6	1.7	0.6	0.0	0.9	2.5
7. Fall from height	5.5	6.8	6.0	3.7	3.6	4.2
8. Homicide	4.9	5.1	1.2	0.0	0.7	5.0
9. Rabies	1.9	0.0	4.8	0.0	1.1	0.0
10. Scorpion bite	1.1	5.1	1.8	0.0	0.7	0.0.
11. Excessive heat	0.4	1.7	0.0	0.0	0.0	0.0.
12. Excessive cold	0.4	0.0	0.0	0.0	0.0	0.0.
13. Not classifiable	7.8	3.4	9.0	1.9	6.6	0.8.

- Karnataka has the least percentage of mortality compared to its neighbours for 'Vehicular Accidents'.
- 'Suicides' ranks below Kerala & Maharashtra, though above national figures.
- 'Burns' account for least deaths except TN
- 'Drowning', "Fall from height" and 'Scorpion bite' account for higher deaths percentages in comparison to all states and national figures.
- Snake bites - below AP / TN / All India.
- 'Natural Calamity' below All India / TN.
- 'Homicide' ranks above all, so does 'Excessive heat' deaths.
- 'Not classifiable' below All India / AP / Maharashtra.

Percentage distribution of deaths under 'Other clear symptoms'.

Source #6

Cause	India	Kar	A.P.	Kerala	Maha	TN
1. Cancers	37.6	47.4	43.8	61.8	33.8	40.8
2. Jaundice	12.0	10.3	2.6	1.1	6.9	17.0
3. Cirrhosis or Chronic liver Disease	9.5	6.2	7.4	11.2	16.3	5.4
4. Diabetes	7.8	19.6	7.4	12.4	6.6	12.2
5. Tetanus	4.8	3.1	1.1	0.0	1.4	4.1
6. Uraemia	4.8	2.1	7.4	3.4	6.1	10.9
7. Measles	3.5	2.1	2.3	0.0	0.2	0.0
8. Mental diseases	3.2	2.1	1.7	3.4	2.8	2.0
9. Hyperplasia of prostate	1.7	1.0	0.6	2.2	0.5	0.0
10. Leprosy	1.4	5.2	2.3	1.1	0.5	2.7
11. Poliomyelitis	1.2	0.0	0.6	0.0	0.0	1.4
12 Chicken pox	0.3	0.0	0.0	2.2	0.0	0.0
13. Obstructed hernia	0.2	0.0	0.0	0.0	0.2	0.6
14. Other medically certified disease.	12.1	1.0	4.0	1.1	24.6	2.7

Cancers – less than Kerala / more than others.
Jaundice - less than AP / TN / India.
Cirrhosis - less than all except TN.
Leprosy & Diabetes - Maximum ~~done~~ in Karnataka
Tetanus – less than All India / more than Others.
Uraemia / Polio / Chicken pox / Obstructed hernia – least in Karnataka and TN
Measles – less than India / AP.
Mental diseases – more than Kerala / Maha & less than others.
Prostate – less than All India & Kerala
~~Leprosy~~ "Others" → least in Karnataka.

Percentage distribution of deaths due to ten selected important diseases. – 1991

Source #6

Cause	India	Kar	AP	Kerala	Maha	T.N.
1. Bronchitis & Asthma	8.2	11.6	8.1	12.4	7.4	7.7
2. Heart Attack	5.8	7.2	7.9	16.7	4.6	13.3
3. T.B. of Lungs	5.3	5.8	7.1	2.4	4.3	4.6
4. Prematurity	4.9	4.7	3.1	0.8	9.8	2.0
5. Pneumonia	4.6	1.7	0.3	0.6	5.6	0.7
6. Cancer	3.1	5.0	4.4	11.6	3.0	3.9
7. Anaemia	3.0	3.7	1.7	1.5	1.5	3.1
8. Paralysis	3.0	4.4	6.1	13.7	2.1	5.7
9. Vehicular Accidents	1.9	0.5	1.4	2.7	2.3	1.4
10. Gastroenteritis	1.9	0.9	1.3	1.3	0.6	0.9
11. Others	58.2	54.5	58.5	35.2	58.9	56.7

The major killers among the ten selected diseases in comparison, when the top five are taken, is as follows -

Karnataka –	Bronchitis & Asthma	Heart Attacks	TB of lungs	Cancers	Prematurity
A.P. –	Bronchitis & Asthma	Heart attacks	TB of lungs	Paralysis	Cancers
Kerala –	Heart attacks	Paralysis	Bronchitis & Asthma	Cancers	T.B. of lungs.
Maha –	Prematurity	Bronchitis & Asthma	Pneumonia	Heart attacks	T.B. of lungs.
TN –	Heart attacks	Bronchitis & Asthma	Paralysis	T.B. of lungs	Cancers.

Sources

#1. ASOK MITRA - ~~India's Stagnant States~~
Census 1991 - India's Stagnant Status; ASOK MITRA -
Frontline - April 13-26, 1991 pp 33-42
VENKATESH ATREYA
Literacy 1991 : Inter-state variations
Frontline - April 13-26, 1991 pp 43-44.

#3. Statistical Outline of India 1992-93
Tata Services Limited
Department of Economics & Statistics.

#2. Dr. R. Indira - "District Census figures 1991 and their implications"; R-1 INDIRA -
Deptt. of Studies in Sociology,
University of Mysore (28 Oct 1992)

#4. Karnataka and India at a glance (as on 31/3/1992)
Management Information and Evaluation, Division
Directorate of Health and Family Welfare Services
Bangalore - 560 009.

#5. Health Information of India - 1991
Central Bureau of Health Intelligence
Ministry of Health and Family Welfare,
Govt. of India.

#6. Survey of Causes of Death (Rural)
Ministry of Home Affairs Series ~~No.~~ 3-No 24
Government of India. (1991 data).

KARNATAKA AND INDIA
AT A GLANCE

ಕರ್ನಾಟಕ ಮತ್ತು ಭಾರತದ

ಒಂದು ನೋಟ

(As on 31-3-1992)
(31-3-1992ರಲ್ಲಿ ಇದ್ದಂತೆ)

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ಇವರಿಂದ ಪ್ರಕಟಿತ
ಮಾಹಿತಿ ನಿರ್ವಹಣೆ ಮತ್ತು ಮೌಲ್ಯ ಮಾಪನ ವಿಭಾಗ
ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಸೇವೆಗಳ ನಿರ್ದೇಶನಾಲಯ
ಬೆಂಗಳೂರು-೫೬೦ ೦೦೯

KARNATAKA AND INDIA AT A GLANCE

ಕರ್ನಾಟಕ ಮತ್ತು ಭಾರತದ ಒಂದು ನೋಟ

*(As on 31-3-1992*ರಲ್ಲಿ ಇದ್ದಂತೆ)

1. **General Information**/ಸಾಮಾನ್ಯ ಮಾಹಿತಿ	*Karnataka*/ಕರ್ನಾಟಕ	*India*/ಭಾರತ
Area in Sq. Kms./ವಿಸ್ತೀರ್ಣ (ಚ.ಕಿ.ಮೀ)	1,91,791	32,87,263
No. of Revenue Divisions/ರೆವಿನ್ಯೂ ವಿಭಾಗಗಳ ಸಂಖ್ಯೆ	4	NA
No. of Districts/ಜಿಲ್ಲೆಗಳ ಸಂಖ್ಯೆ	20	412
No. of Sub-Divisions/ಉಪ ವಿಭಾಗಗಳ ಸಂಖ್ಯೆ	49	NA
No. of Taluks/ತಾಲ್ಲೂಕುಗಳ ಸಂಖ್ಯೆ	175	NA
No. of Towns and Cities (1991 Census)/ಪಟ್ಟಣ ಮತ್ತು ನಗರಗಳ ಸಂಖ್ಯೆ (1991ರ ಜನಗಣತಿ) (ತಾತ್ಕಲಿಕ)	254	3,768
No. of inhabited villages (1981 census)/ಜನವಸತಿ ಇರುವ ಗ್ರಾಮಗಳ ಸಂಖ್ಯೆ (1981ರ ಜನಗಣತಿ)	27,024	5,57,137
2. Demographic Features (1991 Census) (Provisional) : ಜನಸಂಖ್ಯಾ ಲಕ್ಷಣಗಳು (೧೯೯೧ರ ಜನಗಣತಿ) (ತಾತ್ಕಾಲಿಕ)		
Population (in 000s)/ಜನಸಂಖ್ಯೆ (000ಗಳಲ್ಲಿ)	44,806	8,44,324
Male Population (in 000s)/ಗಂಡಸರ ಜನಸಂಖ್ಯೆ (000ಗಳಲ್ಲಿ)	22,846	NA
Female Population (in 000s)/ಹೆಂಗಸರ ಜನಸಂಖ್ಯೆ (000 ಗಳಲ್ಲಿ)	21,960	NA
Decinnial Growth Rate (1981-91)/1981-91ರ ದಶಕದಲ್ಲಾದ ಬೆಳವಣಿಗೆ ಪ್ರಮಾಣ	20.66	23.56
Percentage of Urban Population to Total Population ಒಟ್ಟು ಜನಸಂಖ್ಯೆಗೆ ಶೇಕಡಾವಾರು ಜನಸಂಖ್ಯೆ	30.91	25.72
Density of Population per km^2 (1991 Census)/ಪ್ರತಿ ಚದರ ಕಿ.ಮೀ.ಗೆ ಜನ ಸಾಂದ್ರತೆ (1991 ಜನಗಣತಿ)	234	267
Sex Ratio (No. of Females per 1000 Males) ಲಿಂಗ ಪ್ರಮಾಣ (ಪ್ರತಿ 1000 ಪುರುಷರಿಗೆ ಮಹಿಳೆಯರು)	961	929
(*a*) *Percentage of Literacy (1991 Census)*/ಶೇಕಡಾ ಸಾಕ್ಷರತೆ (1991ರ ಜನಗಣತಿ)	55.98	52.11
Male/ಪುರುಷರು	67.25	63.86
Female/ಸ್ತ್ರೀಯರು	44.34	39.42
(*b*) *Expectation of life at birth (in years) (1991-96) (Projected)* ಜನನ ಕಾಲದಲ್ಲಿ ನಿರೀಕ್ಷಿತ ಆಯುಃ ಪ್ರಮಾಣ (ವರ್ಷಗಳಲ್ಲಿ) (1991-96)		
Male/ಪುರುಷರು	64.15	60.6
Female/ಮಹಿಳೆಯರು	65.30	61.7
(*c*) *No of Eligible Couple Protected as on 31-3-1992 (as worked out by Minister of H & FW)* ಅರ್ಹ ದಂಪತಿಗಳ ರಕ್ಷಣಾ ಪ್ರಮಾಣ ದಿನಾಂಕ 31-3-1992ರಲ್ಲಿ ಇದ್ದಂತೆ (ಆರೋಗ್ಯ ಮತ್ತು ಕು. ಕ. ಕಲ್ಯಾಣ ಸಚಿವಾಲಯದ ಲೆಕ್ಕಾಚಾರದಂತೆ)	49.4	44.1 (1991)
(*d*) *Percentage of Married Females to total Females in the age group of 15–44*/15-44ರ ವಯೋಮಾನದಲ್ಲಿನ ಒಟ್ಟು ಹೆಂಗಸರಲ್ಲಿ ವಿವಾಹಿತರಾದ ಮಹಿಳೆಯರು–ಶೇಕಡಾವಾರು (1981ರ ಜನಗಣತಿ)	76.08	80.51
(*e*) *Mean Age at Marriage of Female/Male (1991 Census)* ಹೆಂಗಸರ/ಗಂಡಸರ ವಿವಾಹದ ಸರಾಸರಿ ವಯಸ್ಸು (1981ರ ಜನಗಣತಿ)		
Male/ಪುರುಷರು	25.86	23.29
Female/ಸ್ತ್ರೀಯರು	19.21	18.33

	Karnataka/ಕರ್ನಾಟಕ	*India*/ಭಾರತ
(*f*) *Per Capita Income 1988–89 (in Rupees)*-At current prices ತಲಾವಾರು ಆದಾಯ-1988-89 (ರೂಪಾಯಿಗಳಲ್ಲಿ)-(ಪ್ರಸ್ತುತ ದರದಲ್ಲಿ)	3787.00	3835.30

3. Vital Statistics/ಜನನ-ಮರಣಗಳ ಅಂಕಿ ಅಂಶಗಳು

(A) Fertility/ಫಲವತ್ತತೆ

(*a*) *Birth Rate*/ಜನನ ಪ್ರಮಾಣ		
(Provisional 1990/ತಾತ್ಕಾಲಿಕ (೧೯೯೦)		
Rural/ಗ್ರಾಮೀಣ	28.8	31.5
Urban/ಪಟ್ಟಣ	24.8	24.4
Combined/ಸಂಯುಕ್ತ	27.8	29.9
(*b*) *Age specific Fertility Rates (1986)*/ವಯೋಮಾನವಾರು ಫಲವತ್ತತೆಯ ಧರ (೧೯೮೬)		
Years/ವರ್ಷಗಳು		
15....19	88.8	91.1
20....24	230.2	252.8
25 .. 29	180.3	216.4
30....34	103.9	139.2
35 . 39	60.4	78.6
40 .. 44	22.8	37.7
45 49	6.9	14.9
(*c*) *Total Fertility Rates (1986)*/ಒಟ್ಟು ಫಲವತ್ತತೆಯ ಧರ (೧೯೮೬)		
Rural/ಗ್ರಾಮೀಣ	3.7	4.5
Urban/ಪಟ್ಟಣ	2.9	3.1
Combined/ಸಂಯುಕ್ತ	3.5	4.2
(*d*) *Gross Reproduction Rate (1986)*/ಒಟ್ಟು ಸಂತಾನೋತ್ಪತ್ತಿ ಪ್ರಮಾಣ (೧೯೮೬)		
Rural/ಗ್ರಾಮೀಣ	2.1	2.2
Urban/ಪಟ್ಟಣ	1.6	1.5
Total/ಒಟ್ಟು	2.0	2.0

(B) Mortality/ಮರಣ

(*a*) *Death Rate*/ಮರಣ ಪ್ರಮಾಣ		
Provisional (1990) ತಾತ್ಕಾಲಿಕ (೧೯೯೦)		
Rural/ಗ್ರಾಮೀಣ	8.8	10.4
Urban/ಪಟ್ಟಣ	6.1	6.7
Combined/ಸಂಯುಕ್ತ	8.1	9.6
(*b*) *Infant Mortality Rate*/ಶಿಶುಮರಣ ಪ್ರಮಾಣ		
(Provisional 1990/ತಾತ್ಕಾಲಿಕ 1990)		
Rural/ಗ್ರಾಮೀಣ	81	86
Urban/ಪಟ್ಟಣ	39	51
Combined/ಸಂಯುಕ್ತ	71	80
(*c*) *Neo-natal and Post natal Mortality Rates (1986)* ನವಜಾತ ಶಿಶು ಮರಣ ಧರ (೧೯೮೬)		
Neo-natal/ಜನನಾನಂತರ ೭ ದಿನಗಳ ಒಳಗೆ	54.4	59.8
Post-natal/ಜನನಾನಂತರ ೭ ದಿನದಿಂದ ೩೬೫ ದಿನಗಳ ಒಳಗೆ	18.8	36.6

	Karnataka/ಕರ್ನಾಟಕ	*India*/ಭಾರತ
4. Percentage of Population below Poverty line (1987-88) (Provisional) ಬಡತನದ ರೇಖೆಯ ಕೆಳಗಿರುವ ಜನಸಂಖ್ಯೆ ಶೇಕಡಾವಾರು (೧೯೮೭-೮೮) (ತಾತ್ಕಾಲಿಕ)		
Rural/ಗ್ರಾಮೀಣ	35.87	32.66
Urban/ಪಟ್ಟಣ	NA	NA
Combined/ಸಂಯುಕ್ತ	31.98	29.23
5. Per Capita (Public Sector) Expenditure on Health (Medical and Public Health) and Family Welfare (86-87) (In Rs.) ಆರೋಗ್ಯ (ವೈದ್ಯಕೀಯ ಮತ್ತು ಸಾರ್ವಜನಿಕ ಆರೋಗ್ಯ) ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ತಲಾವಾರು (ಸಾರ್ವಜನಿಕ ವಲಯ) ವೆಚ್ಚ (೧೯೮೬-೮೭) ರೂ. ಗಳಲ್ಲಿ		
Health/ಆರೋಗ್ಯ	40.59	54.57
Family Welfare/ಕುಟುಂಬ ಕಲ್ಯಾಣ	9.59	7.61
6. (*a*) Health and Medical Institutions ಆರೋಗ್ಯ ಮತ್ತು ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳು		
General Hospitals, Major Hospitals and District Hospitals ಸಾರ್ವಜನಿಕ ಆಸ್ಪತ್ರೆಗಳು, ದೊಡ್ಡ ಆಸ್ಪತ್ರೆಗಳು ಮತ್ತು ಜಿಲ್ಲಾ ಆಸ್ಪತ್ರೆಗಳು	293(p)	10172⊕
Primary Health Centres/ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳು	1262	20531⊕
Primary Health Units/Dispensries/ಪ್ರಾ. ಆ. ಘಟಕಗಳು/ಔಷಧಾಲಯಗಳು	831(p)	28304⊕
No. of Beds/ಹಾಸಿಗೆಗಳ ಸಂಖ್ಯೆ	48439(p)	625418⊕
No. of Sub-Centres/ಉಪಕೇಂದ್ರಗಳ ಸಂಖ್ಯೆ	7,793	13090 ⊕
Rural Family Welfare Centres/ಗ್ರಾಮೀಣ ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕೇಂದ್ರಗಳು	269	5345 ▼
Urban Family Welfare Centres/ನಗರ ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕೇಂದ್ರಗಳು	102	1941 ○
Post Partun Centres/ಬಾಣಂತನ ಸೇವಾ ಕೇಂದ್ರಗಳು	103	1501°
Medical Termination of Pregnancy (MTP) Centres/ ವೈದ್ಯಕೀಯ ಗರ್ಭಪಾತ (ಎಂಟಿಪಿ) ಕೇಂದ್ರಗಳು	471	NA
Health and Family Welfare Training Centres/ ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ತರಬೇತಿ ಕೇಂದ್ರಗಳು	5	NA
(*b*) *Institution Population Ratio*/ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆ–ಜನಸಂಖ್ಯೆ ಪ್ರಮಾಣ (For Census Population of 1991)/(1991ರ ಜನಗಣತಿಯ ಜನಸಂಖ್ಯೆಗೆ)	1: 21,740(P)	1 : 1000°°
(*c*) *Bed Population Ratio*/ಹಾಸಿಗೆ–ಜನಸಂಖ್ಯೆ ಪ್ರಮಾಣ	1: 1355(P)	1 : 1398▼
(*d*) *Doctor Population Ratio (Govt.)*/ವೈದ್ಯರು ಜನಸಂಖ್ಯೆ ಪ್ರಮಾಣ (ಸರ್ಕಾರಿ)		1 : 2450*
Excluding Teaching Staff/ಬೋಧಕ ಸಿಬ್ಬಂದಿಯನ್ನು ಹೊರತುಪಡಿಸಿ	1: 10,230	NA
Including Teaching Staff/ಬೋಧಕ ಸಿಬ್ಬಂದಿಯನ್ನು ಒಳಗೊಂಡಂತೆ	1: 8418	NA
(*e*) *Auxiliary Nurse Midwife/Midwife Population Ratio (Govt.)*/ ಶುಶ್ರೂಷಕದಾದಿ/ಸೂಲಗಿತ್ತಿ–ಜನಸಂಖ್ಯೆ ಪ್ರಮಾಣ (ಸರ್ಕಾರಿ)		
For Total Population/ಒಟ್ಟು ಜನಸಂಖ್ಯೆಗೆ	1: 4,904	1 : 2036 *
(*f*) *Nurse Bed Ratio*/ದಾದಿಯರ ಹಾಸಿಗೆ ಪ್ರಮಾಣ	1: 8	1 : 3°°

(P) Provisional as on 31-3-92 ⊕ as on 31-3-90 * 1985 ▼ 1986 °° 1-1-1988
° 31-3-1987 ○ 31-3-89 (p) Provitivnal

ಮುದ್ರಣ : ಇಲಾಖೆಯ ಆಫ್‌ಸೆಟ್ ಮುದ್ರಣಾಲಯ

TABLE-9.4

Selected Indicators of Vocational Education in Karnataka

Item/Unit	1990-91	1991-92	1992-93	1993-94 (Anticipated)
1. No. of Institutions	283	328	474	589
2. No. Enrolled	14,500	16,000	25,000	30,000
3. Expenditure: (Rs. lakhs)				
(a) Plan				
i) State Plan	11.50	-	-	296.34
ii) Centrally Sponsored Schemes	172.73	207.00	600.00	1342.42
(b) Non-Plan	168.17	152.16	177.85	43.67

Source: Department of Vocational Education.

2. HEALTH AND FAMILY WELFARE

The Department of Health and Family Welfare has the responsibility of providing comprehensive health care facilities through various programmes, schemes and various types of health institutions. The main objectives of the Department are as follows:

- To effect improvement in Medical care and to provide Medical Relief.
- To undertake, National Health Programmes for control and eradication of communicable diseases and other major diseases.
- To promote education in health protection and health development.
- To take suitable measures to prevent food adulteration.
- To provide services, like maternal and child health, family welfare, immunization, prophylaxis against nutritional anemia and control of blindness; and
- To promote health education and training in various medical disciplines.

Primary Health Care

Primary health care is one of the items under the restructured 20 - point programme. The State is following the national pattern of three tier health infrastructure in rendering primary health care through Primary Health Centres, Sub-Centres and Community Health Centres. The policy of the Government is to establish one primary health centre for every 30000 population in plain areas and for every 20000 population in hilly and tribal areas, one sub-centre with a female health worker for every 5000 population in plain areas and for every 3000 population in hilly and tribal areas and one Community Health Centre for one lakh population or one out of four primary health centres to be made to function as referral/specialised institution for the rural population.

The earlier scheme of establishing Primary Health Centres has been discontinued and the existing Primary Health Units will be upgraded into Primary Health Centres in a phased manner.

At present there are 176 hospitals, 198 Community Health Centres, 1297 Primary Health Centres, 622 Primary Health Units and 7793 sub-centres functioning in the State.

Government has sanctioned the following Schemes during 1993-94:

1. Trauma Care Units to Community Health Centres:
   i) Challakere, Chitradurga District.
   ii) Bhadravathi, Shimoga District.
   iii) Nanjangud, Mysore District.

2. Maternity Annexes to:

   i) Begewalu PHC, Arasikere Taluk, Hassan District.
   ii) Kallur KHC, Gubbi Taluk, Tumkur District.

3. Modified Leprosy control unit to Nelamangala and Kumta.

4. Urban Leprosy Centres at Shimoga & Jamkhandi(Bijapur Dt).

5. Blood Bank at Chamarajanagar General Hospital, Mysore Dt.

6. Filaria Control Unit at Ilkal.
7. Filaria Clinic at Kamatagi, Bijapur District.
8. 100 beds for maintenance of Leprosy patients by voluntary organisations.

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9. Enhancement of bed strength from 60 to 100 in M.C.M. General Hospital, Mudigere Taluk, Chickmaglur District.
10. Enhancement of bed strength from 50 to 150 beds of General Hospital, Chinthamani, Kolar District.
11. Establishment of 49 Primary Health Centres.
12. Establishment of 14 Community Health Centres.

Tables 9.5, 9.6 and 9.7 present basic indicators of health facilities and impact, indicators of health and quality of physical life and plan and non-plan expenditure on Health and Family Welfare.

TABLE-9.5
Selected Indicators of Health Facilities and Impact

Physical Indicators	1990-91	1991-92	1992-93	1993-94 (Anti.)
1. No. of Primary Health Centres	1198	1248	1297	1357
2. No. of Sub-Centres	7793	7793	7793	7793
3. Crude Birth Rate	27.9	27.8	26.8	26.8
4. Crude Death Rate	8.7	8.1	9.0	9.0
5. Infant Mortality Rate	80	71	77	77
6. Life Expectancy - Male	62.15	-	-	-
Female	63.31			
7. Eligible Couples Estimated	7170720	7293680	7416597	7416597
8. Couples Protected	3410953	3583323	3726870	3726870
9. Proportion of Couples protected (per cent)	47.6	49.1	50.3	50.3

Source: Department of Health and Family Welfare Services.

TABLE-9.6
Indicators of Health and Quality of Physical Life
Karnataka and India

Indicator	Karnataka	India
1. Birth Rate (1991)		
Rural	27.8	30.8
Urban	23.9	24.1
Combined	26.8	29.3
2. Death Rate (1991)		
Rural	9.7	10.5
Urban	6.9	7.0
Combined	9.0	9.8
3. Infant Mortality Rate (1991)		
Rural	87	86
Urban	47	52
Combined	77	80
4. Expectation of Life at Birth		
Male	64.15	60.6
Female	65.30	61.7
5. Dependency Ratio: (No. of persons in the age group of 0.14 and 60 and above per 1000 persons in age group 15-59)	858	854

Sources: Department of Health and Family Welfare Services.

TABLE-9.7
Plan and Non-Plan Expenditure on Health and Family Welfare

Rupees lakhs

Year	Plan Expenditure	Non-Plan Expenditure
1990-91	8341.63	16616.56
1991-92	9504.85	20559.96
1992-93 (RE)	13874.84	25206.06
1993-94 (BE)	18472.77	28483.26

Note: These figures are compiled from Finance Accounts and AFS - different issues.

3. ENVIRONMENT

I. HOUSING

Food, clothing and shelter are the three minimum basic needs of people. Increasing population, pressure on land and infrastructure and associated high costs have made proper housing inaccessible to the poorer segments of the population necessitating state intervention initially as a welfare activity and now recognised as a social and economic imperative. Keeping this in view the policies and programmes have been formulated to fulfil the housing requirements of majority of economically vulnerable sections as well as to create an enabling environment to accomplish the goal "Shelter for all" on a self sustaining basis. The main objective of the programme is to provide sufficient units for the economically weaker sections.

a) Housing scene

As per 1991 census, there were about 79.6 lakh dwelling units in Karnataka out of which 54.2 lakhs in rural areas and the remaining 25.4 lakhs in urban areas.

b) Rural Housing

The scheme of allotment of housesites and construction assistance to rural landless workers and artisans including Scheduled Castes and Scheduled Tribes was initiated as a Central Sector Scheme which was later transferred to State in 1974. It is a part of Minimum Needs Programme. Upto the end of November 1993 about 17 lakh beneficiaries got house sites (Appendix 9.6). During 1991-92 a little over 4 lakh sites have been distributed. In the following year 1992-93, it was 1.57 lakhs. From the year 1992-93, a Massive Programme of distribution of house sites and providing construction assistance were launched under ASHRAYA SCHEME. The salient feature of this scheme are :

(i) to provide shelter to the economically weaker sections of the society as quickly as possible;

(ii) to eliminate the houselessness by the turn of the century by adopting a new housing strategy for the target groups;

(iii) to enable the local bodies/corporations to serve the public and contribute and implement the project in a more effective and efficient manner by providing adequate technical and financial support;

(iv) to rehabilitate the slum dwellers in the City of Bangalore in a phased manner;

(v) to promote the usage of locally manufactured building materials with pre-fabricated technology in the long run.

The main target-group eligible under Ashraya Scheme are:

(i) people whose annual income falls below Rs.8,400 in Rural and Urban areas in the State excluding Bangalore City;

(ii) the slum dwellers of the Bangalore City whose income is between Rs.8,401 and 18,000 per annum.

The unit cost of a house under Ashraya Scheme is as follows:-

	Unit cost Rs.	Loan Rs.	Subsidy Rs.
Rural	15,000	10,000	5,000
Urban	16,000	14,000	2,000
Banglore	33,000	28,000	5,000

(50% of the cost of the site in Urban areas is to be contributed by the beneficiary).

The progress achieved under the various schemes of construction of houses in rural area from 1973-74 upto December 1993 is given in Appendix 9.7.

The target fixed under Ashraya Scheme during 1993-94 was to construct 1.06 lakh E.W.S. houses and distribute 1 lakh sites. Out of which 0.19 lakh houses were constructed and 0.48 lakh sites were distributed upto the end of Nov. 1993.

Neralina Bhagya:

In addition to providing sites and construction of houses under Ashraya Scheme, a new scheme called NERALINA BHAGYA was introduced during 1993-94 with the object of replacing thatched roof with tiled roof at a unit cost Rs.3,000/- per house.

C) Urban Housing

Housing Schemes implemented in urban areas are as under:

(i) housing schemes for different income-groups operated by Karnataka HOusing Board;

(ii) Sites distribution in Bangalore City by Bangalore Development Authority and by Urban Development Authorities in other urban areas;

(iii) construction of EWS houses for slum dwellers by the Karnataka Slum Clearance Board;

(iv) housing and shelter upgradation scheme for urban poor as a part of Nehru Rozgar Yojana (NRY).

(v) construction of quarters for Govt. employees in Bangalore and other places.

About 92 thousand houses were constructed in urban areas under the schemes of Bhagya Mandir, Middle Income Group, Low Income Group and Economically for Weaker Sections from 1970-71 to 1992-93. The scheme-wise progress achieved is presented in Appendix.9.8.

II RURAL WATER SUPPLY AND SANITATION

a)Rural Water Supply

The total population of the State as per 1991 census was 449.77 lakhs out of which the rural population was 310.69 lakhs which constitutes 69 percent of the total population. This rural population is spread over 29,193 revenue villages and 27,496 habitations (hamlets, Thandas, Janatha HOusing Colonies).

Karnataka is one of the pioneer states to provide atleast one safe drinking water source for all the revenue villages by 1986 itself. Even, all the habitations like Hamlets, Thandas, Janatha Housing Colonies have also been provided with atleast a single drinking water source before March 1993. At the begining of VI Five Year Plan, Government of India came forward to support the State Government financially by providing additional financial inputs under the Central Sector Scheme called: Accelerated Rural Water Supply Programme (ARWSP). After conducting a survey, for identifying problematic villages, 20,003 villages were identified as problematic villages out of the revenue villages in the State. All these villages were provided with atleast single drinking water source by 1986.

During VII Five Year Plan (1985-90), modified norms were followed for identifying the problematic villages/habitations. In addition to the 1980 list, 17,132 habitations out of 25,595 habitations were identified as problematic habitations. All the uncovered villages have been covered.

The status of the coverage of the problematic villages/habitations as on 1-11-1993 is as detailed below:

Number:

Catagory of Villages/ habitations	Identified as Problematic			coverage as on 1-11-1993		
	Villages	Habitations	Villages & Habitations			
	1980 list	1985 list	Total	1980 list	1985 list	Total
Not covered	20,003	5,397	25,400	-	-	-
Partially Covered	-	11,735	11,735	241	9,252	9,493
Fully covered	-	-	-	19,762	7,880	27,642
Total	20,003	17,132	37,135	20,003	17,132	37,135

The water supply schemes for other villages and habitations (Non-problematic) are tackled under the State Sector Schemes namely 'Minimum Needs Programme' (MNP). Water Supply to Rural areas is accomplished through piped water supply, mini water supply and borewells fitted with hand-pumps. Of the total 29193 revenue villages (as per 1991 census) in the State 7818 villages were covered under piped water supply scheme, 6726 villages under mini water supply schemes and 14649 villages under borewells programme. The achievements under Rural Water Supply from 1970-71 upto the end of November 1993 are presented in Appendix 9.9.

b)Rural Sanitation

Improved Sanitation is considered as an important element of basic needs of the people. It is also recognised that improvement in sanitary conditions is more effective and at the same time less expensive than any other preventive health measures to combat water-borne and excreta-borne diseases. Hence the State launched construction of low cost pour flush water seal sanitary latrines in rural areas during 1984-85. This pilot Project contemplated construction of 1600 latrines to individual households at a total cost of Rs.16 lakhs. But actually 1016 pour flush water seal latrines with two leaching pits could be constructed during the year at an expenditure of Rs.9.75 lakhs. The beneficiaries were identified amongst the economically weaker sections of the rural population.

To augument the efforts made by the State Government in promoting better sanitary habits amongst the rural folk, the Government of India launched a massive rural sanitation programme (RSP) with 100% central assistance, and also made provision for taking up works under RLEGP and NREP. Under CRSP, beneficiaries were selected from among the people belonging to SC/ST and those below the poverty line. Government of India has now extended this benefit to selected Anganawadis also. During 1992-93 as many as 4202 latrines were constructed as against 897 latrines constructed during 1991-92. For the year 1993-94 Rs.115 lakhs, and Rs.266 lakhs have been provided for State and Central Sector Programmes respectively for construction of 9908 units both under State and Central Sector. During 1993-94 (upto the end of December 1993) Rs.26.3 lakhs has been spent and 2246 latrines were constructed.

Since inception and upto the end of December 1993, about 65579 individual household latrines have been constructed in the rural areas, out of which, 40418 units have been completed under Nirmala Grama Yojana and the rest have been constructed under CRSP and MNP Funds.

c)Urban Water Supply

The Karnataka Urban Water Supply and Drainage Board (KUWSDB) was set up in 1975. It is responsible for planning, designing and execution of Water Supply and drainage Schemes in Urban Areas of the State except Bangalore City. Karnataka Urban Water Supply and Drainage Board has jurisdiction over 172 Urban Areas of the State, covering a population of nearly 90.90 lakhs. The Board is executing the following Water Supply and Sewerage Schemes.

i)Piped Water Supply Schemes

The works under this scheme are taken up in urban area where the population is less than 20,000 as per 1991 Census with 100 percent grant from the Government. Since inception as many as 125 towns have been covered upto 1992-93 under this scheme covering a population of 19.35 lakhs. As many as 10 towns were covered under PWS during 1992-93, while the likely coverage during 1993-94 is 8 towns.

ii)Urban Water Supply Schemes

Urban areas with a population of above 20,000 comes under this catagory. These schemes are financed partly by LIC/HUDCO and Government as loan to the local Authority which would be responsible for its repayment with interest. The remaining amount would be financed by the concerned local body viz., CC/CMC/TMC itself depending upon the pattern of funding approved by the Government.

Three towns each were covered under urban water supply scheme during 1991-92 and 1992-93 with an expenditure of Rs.10.53 crores and 21.90 crores respectively. The anticipated achievement during 1993-94 is 9 towns.

iii)Board Water Supply Schemes

The Board Water Supply schemes are executed by the Karnataka Urban Water Supply & Drainage Board as per the directions of the Government after obtaining loans from Government and LIC. The repayment of loan (with interest) thus raised will have to be made by the Board. Further, the board also maintain the works completed under its water supply schemes. One town during 1991-92 and 2 towns during 1992-93 were covered with an expenditure of Rs.8.50 crores and Rs.10.72 crores respectively.

iv) Underground Drainage Schemes

All Urban areas irrespective of their population come under this category of schemes and they are financed partly by LIC and HUDCO. The underground drainage schemes were completed in two towns during 1991-92. The anticipated achievement for the year 1993-94 is 3 schemes.

The progress under the above Water Supply and Drainage Schemes from 1986-87 to 1992-93 is given in appendix 9.10.

III SLUM IMPROVEMENT

In all, 1615 slum areas have been identified with an estimated population of 20 lakhs upto the end of December 1993. The board is implementing two schemes namely (1) Slum Improvement and (2) Clearance Schemes(Construction of EWS Houses).

1. Slum Improvement

Under this scheme, the Board is providing the basic amenities like Roads, Drains, Street lights, community bathroom, community latrine, sewerage, community halls, drinking water to the slum areas. So far 939 slum areas have been improved by spending an amount of Rs.1,461.76 lakhs.

2. Clearance Schemes (Construction of EWS houses)

Under this scheme, the Board is constructing EWS houses either in a slum area itself by clearing the huts or in the available vacant land to rehabilitate the slum dwellers. Upto end of March 1993, the Board has completed 10791 houses by spending an amount of Rs.2002 lakhs.

Apart from the above two schemes, the Board has introduced a new scheme called "Site and Service" for the upliftment of the slum dwellers from 1991-92 onwards. Under this scheme, the sites will be formed with all infrastructure facilities and distributed to the slum dwellers.

The Board is also constructing the "Sulabha Shouchalayas" in the busy areas of the town limits. So far 56 Shouchalayas have been completed at a cost of Rs.90.72 lakhs.

The details of progress achieved from the year 1986-87 to 1992-93 under the programme of environmental improvement of slums are given in Appendix 9.11.

4. NUTRITION

The Nutrition programme in the State has three components viz., (1) Supplementary Nutrition Programme in ICDS (Women and Child Development Directorate); (2) Mid-day Meals (Education Department) and (3) Supply of Foodgrains to the poor at subsidised rates (Food and Civil Supplies Department).

a) Supplementary Nutrition Programme in ICDS

The Supplementary Nutrition Programme is one of the most important components among the package of services offered under the ICDS programme, which was launched in the State from December 1975 with a pilot project at T.Narasipura in Mysore District. Selected children below 6 years, pregnant women and nursing mothers belonging to weaker sections of the society are the beneficiaries under this programme. They are given Supplementary Nutrition worth 75 paise per beneficiary per day for 300 days in a year. There is a proposal to increase this to Rupee 1.00 per beneficiary per day, shortly. Expert opinion claims that there is a deficit of 300-500 calories of energy and 10-12 grams of proteins in a normal Indian child. Likewise pregnant women, nursing mothers and severely malnourished children need an additional 500 calories of energy and 20-25 grams of proteins. With a view to compensate this deficiency, the Government of India has introduced Supplementary Nutrition Programme with State expenditure in the ICDS Programme. Double feeding is being given to the pregnant women, nursing mothers and severely malnourished children in the Anganwadis. 27% of the total beneficiaries belong to Scheduled Caste and Scheduled Tribes and 12% belong to the minority communities. Presently in the operational 148 ICDS projects Supplementary Nutrition is being provided. The Supple-mentary Feeding pattern is detailed as follows:

No.of Existing Projects		Feeding Pattern
a) CARE projects:-	97	65 grams CSM/CSB and 8 grams S.Oil + ingredients worth 20 paise per beneficiary per day.
b) Non-CARE projects:	49	100 grams of wheat recipes for 2 days,100 grams of rice recipes for 2 days and 80 grams energy food for 2 days.Feeding cost is 75 paise per beneficiary per day including ingredients used in the preparation of recipes.
c) Bangalore(U) Projects:-	2	2 slices of Milk bread per beneficiary for children (1-6 years).pregnant women and nursing mothers; cost per beneficiary per day is 90 paise.

While the cost relating to the Supplementary Nutrition is entirely borne by the State Government, the entire administrative expenditure in respect of 118 central projects is met by the Central Government (including ICDS cells).

b. Mid-Day Meals Programme

The Mid-Day Meals Programme was started in 1963 with the assistance of CARE as an incentive programme for Primary School Chidren. The main objectives of this mid-day meals programme are:

(1) to provide supplementary nutrition to the Chidren in the age group of 6-11 years, particularly of weaker sections of the Society and thereby to improve the health status of the Children;

(2) to fecilitate to improve enrolment of children; and

(3) to facilitate rentention of the enrolled children in the School.

The programme has been classified into two categories according to the nature of food assistance to the beneficiaries:

I) CARE assisted Mid-day Meals Programme.
II) Energy Food Programme.

I) CARE Assisted Mid-Day Meals Programme

The food commodities such as Bulgar wheat and salad oil are provided by CARE free of cost. Food will be prepared by cooking at the rate of 80 grams of bulgar wheat and 5 grams of salad oil per day per beneficiary. This CARE-assisted Mid-Day Meals Programme for Primary School Children was closed at the end of 1992-93.

II) Energy Food Programme

In addition to CARE food programme, Energy Food Programme was started as a supplementary programme from 1980-81 in Karnataka.

Food supplements like CSM, Balahar are blends of unroasted material requiring eloborate cooking arrangements at the point of distribution. Bread, Biscuits, Extruded Foods are pre-cooked food but are costly. Therefore, Central Food and Technological Research Institute (CFTRI) suggested a product called "Energy Food". which is pre-cooked weaning food formula, developed by them for "India population project " in

Chitradurga District. Due to its success over a period of five years Energy Food formulation was adopted to Energy Food Project. Accordingly five units located at Mysore, Belgaum, Chitradurga, Raichur and Doddaballapura are in operation. UNICEF has provided machineries for these units. Remaining assistance is provided by Government of Karnataka for setting up of these units.

Energy Food is a weaning food formula consisting of Sweet blend and pre-cooked wheat, Bengalgram Dhal, Steam treated Soya Dhal, Jaggery, Edible groundnut cake, Edible Grade Soya Flour, Vitamins and Mineral Mix. 100 grams of Energy Food gives 12-14 grams of protein and 380 calories and adequate vitamins and mineral supplements. It is ready to eat and does not require elaborate cooking arrangements at distribution point.

The Energy Food supplied to the individual feeding centres is distributed to School Children particularly of weaker sections studying in 1-7th Standards in the Lunch break at the rate of 100 grams per child per day.

For this Energy Food Programme Rs.109.00 lakhs is provided under Plan (State and District Sectors together), Rs.11.00 lakhs is provided under Tribal Sub-Plan and Rs.34.24 lakhs is provided under non-plan during the year 1993-94. 2.04 lakhs beneficiaries are expected to be covered under this Energy Food Programme during 1993-94.

Table 9.8 indicates trends in expenditure over the years 1990-91 to 1993-94 and number of beneficiaries under both the Nutrition programmes (See Appendix 9.12 for details).

TABLE-9.8
Nutrition Programme in Karnataka

Item/Unit	1990-91	1991-92	1992-93	1993-94 (Anti.)
A. Supplementary Nutrition Programme:				
1. Plan Expenditure (Rs. lakhs)	709.12	661.09	894.53	1026.00
2. Beneficiaries ('000s	1281	1673	1875	2263
B. Mid-Day Meals Programme:				
1. Plan Expenditure (Rs. lakhs)	30.36	36.89	72.00	120.00
2. Beneficiaries (lakhs)				
- CARE Food Programme	7.00	4.66	2.34	-
- Energy Food Programme	5.62	6.79	4.76	2.04

Source: A Directorate of Women and Children Welfare
B Department of Public Instruction.

c. Subsidised Foodgrains for the Poor

There are two schemes implemented viz., Green Card (Tri-colour) scheme and scheme for supplying Foodgrains at subsidised rates to the population in Tribal Areas. The main objective of both these schemes is to ensure supply of essential commodities to the needy and vulnerable sections of the community.

i) Green Card (Tri-colour) Scheme

Government introduced a scheme of supply of foodgrains at subsidised rates to the rural poor in 1985. Families in rural areas whose annual income did not exceed Rs.3,500/- were given green cards. However, from October 1991 the income limit for green cards is enhanced to cards were replaced by tri-colour cards. A massive resurvey of beneficiaries was taken up all over the State. There were 31 lakh green cards before survey. So far, 46 lakh tri-colour cards have been distributed in the State. Further, the benefit of tri-colour cards is also extended to the declared slums in urban areas. These tri-colour card holders are entitled for a mix of 10 Kgs of rice and wheat at subsidised rates (i.e. Rs.4.15 per Kg of rice and Rs.2.75 per Kg. of wheat). However, the green card holders are entitled for more quantity beyond 10 Kgs, under the PDS at normal rates. A unique feature of the above scheme involves the responsibility of the State Government in transporting food grains from taluk level to the doors of the Fair Price Shops in rural areas. A provision of Rs.70 crores has been made for the current year 1993-94 to meet the subsidy and transportation charges.

ii) Scheme for Supplying Foodgrains at Subsidised Rates to the Tribal Population

This is a Government of India scheme under implementation since 1986. It is being implemented in 23 blocks in the districts of Chickmagalur, Kodagu, Dakshina Kannada and Mysore. The card holders are entitled to 10 Kgs of rice and 5 Kgs. of wheat per month at subsidized rates under this programme. To ensure smooth functioning of the scheme, Government of India had sanctioned Rs.50 lakhs for introducing Mobile Fair Price Shop vans and the KFCSC purchased 13 mobile fair price shop vans.

5.ROADS

One of the basic requirements for the allround development of rural economy is the accessibility of villages by all-weather roads and, thereby remove their isolation and pave way for the integrated development of rural areas in the State. The road transport is becoming increasingly important because of its reliability, quickness and flexibility. This is particularly so in view of the fact that the villages entirely depend on road communication facilities for the transportation of their Agricultural products/commercial goods either to a market place or to the railhead. The accessibility of villages means providing all-weather roads upto their periphery. The road length which was 0.84 lakh Km during 1970-71 has increased to 1.34 lakh Km. by 1991-92. In other words, over a period of 22 years about 50 thousand Kms. of road length has been formed (Appendix. 9.13)

As at the end of March 1992, 12649 (47%) villages were connected by all-weather roads, 6747 (25%) villages by fair weather roads, 7433 (27%) villages by Katcha and non-motorable roads and 199 (1%) villages were not connected by any roads. (See Appendix.9.14 for details)

The accessibility of villages according to the population range and village roads by type is as detailed below.

Accessibility of Villages by road as on 31-3-1992

Population range	No.of villages	Number of villages connected by			Not connected by any road
		All weather roads	Fair weather roads	Katcha & non-motorable roads	
0-499	11,289	3,167	2,989	4,952	181
500-999	7,343	3,220	2,204	1,910	9
1000-1499	3,461	2,284	816	354	7
1500 & above	4,935	3,978	738	217	2
Total	27,028	12,649	6,747	7,433	199

6. SOCIAL SECURITY:

The process of development also brings to the fore problems of destitution, desertion and family disintegration. Several Programmes are being implemented for the welfare of destitutes, the handicapped, the elderly people having nobody to support.

(i) Handicapped Persons

For the welfare of the handicapped, a financial assistance at the rate of Rs.50/- per month is being given to each handicapped. About 2.84 lakhs handicapped persons were covered upto the end of September 1993.

(ii) Aged Persons

The Scheme of Old Age Pension to cover elderly persons aged 65 and above without any means of support is being implemented. A pension of Rs.75/- is being given to 5.05 lakh elderly persons during 1993-94.

(iii)Destitute Widows

A programme of providing financial assistance to destitute widows is being implemented since 1984 and a pension of Rs.50 per month is being provided to those whose annual income does not exceed Rs.1500 per annum. About 4.86 lakh beneficiaries were covered under this programme upto the end of September 1993.

The scheme wise expenditure incurred and number of beneficiaries covered under the above schemes are presented in Appendix.9.15.

(iv) Distribution of Sarees and Dothies

A scheme of providing sarees and dothies at subsidised rates to the green-card holders is being implemented since 1985. Annual income limit for the beneficiaries has been enhanced from Rs.3,500 to Rs.10,000. The beneficiaries covered under this programme are landless agricultural labourers, village artisans, small and marginal farmers, old age and widow pension beneficiaries, plantation workers, quarring workers, beedi workers and sandle stick workers. During 1992-93 an amount of Rs.5.05 crores has been spent towards this programme and 28.12 lakh beneficiaries were covered.

(v) Maternity Allowance

Woman who belong to the group of agricultural landless labourers constitute one of the weakest sections of the community and they suffer from malnutrition due to inadequate financial support for getting medical care and for earning their livelihood during pre-natal and post natal period. Therefore, a scheme for the grant of maternity allowance of Rs.100 per month to all women agricultural landless labourers is being implemented since 1984-85. This allowance is payable to them for the birth of first and second child for a period of three months in all covering pre-natal and post-natal periods. An amount of Rs.24.93 crores has been spent towards maternity allowance and 8.31 lakh beneficiaries have been covered from 1984-85 to 1992-93.

The yearwise expenditure incurred and number of beneficiaries covered under the scheme of distribution of subsidised sarees and Dothies and Maternity Allowance are presented in Appendix.9.16.

E Performance under Various Family Planning Methods and expected level of achievement for 1994-95.

I FAMILY WELFARE

Sl. No.	Family Planing Methods.	1992-93 Target	Achieve-ment	%	1993-94 (up to endg Dec'93) Target	Achieve-ment	%
1.	Sterilisation	360,000	331554	92.2	380,000	263287	69.3
2.	I.U.D.	290,000	237820	82.0	300 000	192719	64.2
3.	C.C. Users	280,000	265 022	94.6	357000	283126	79.3
4.	O.P. Users	112,000	81561	72.8	140,000	96072	68.6

II IMMUNISATION.

1.	D PT	1185800	1088063	91.8	1229367	837957	68.2
2.	Polio	1185800	1091043	92.0	1229367	837657	68.1
3.	B C G	1185800	1189461	100.3	1229367	946874	77.0
4.	Measles	1185800	1013485	85.5	1229367	781605	63.6
5.	T.T.(f.w.)	1275100	1216273	95.4	1358345	928024	68.3

TABLE NO.26

IMMUNIZATION PROGRAMME IN KARNATAKA STATE

FROM 1986-87 to ~~1991-92~~ 1992-93

ANTIGEN	1986-87	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
1. D.P.T							
Target	900000	950000	900000	1101100	1201700	1148400	1155800
Achievement	761050	856018	883043	912903	1150591	1065616	1058063
Percentage	84.6	90.1	98.1	82.9	95.7	92.8	91.8
2. POLIO							
Target	900000	950000	900000	1101100	1201700	1148400	1185800
Achievement	748753	804695	871275	908705	1156211	1067586	1091043
Percentage	83.2	84.7	96.8	82.5	96.2	93.0	92.0
3. B.C.G							
Target	900000	950000	900000	1101100	1201700	1148400	1185800
Achievement	792462	936707	995848	1067960	1225048	1133730	1189461
Percentage	88.1	98.6	110.6	97.0	101.9	98.7	100.3
4. MEASELS							
Target	350000	800000	814000	1101100	1201700	1148400	1155800
Achievement	179667	609146	681395	733224	992704	970836	1013485
Percentage	51.4	76.1	83.7	66.6	82.6	84.5	85.5
5. D.T.							
Target	620000	700000	933000	920800	917300	897500	959000
Achievement	589482	731642	714751	731945	846137	872120	956344
Percentage	95.1	104.5	76.6	79.5	92.2	97.2	100.7
6. TYPHOID							
Target	620000	700000	------	------	------	------	
Achievement	347474	480189	------	------	------	------	
Percentage	56.9	68.6					
7. T.T. (P.W)							
Target	900000	1000000	1117000	1207800	1298000	1248700	1275100
Achievement	783123	942625	972970	1042119	1174829	1183935	1216275
Percentage	87.0	94.3	87.1	86.3	90.5	94.8	95.4
8. T.T (10 Yrs)							
Target	400000	500000	500000	889600	816400	801600	856000
Achievement	168688	345033	394145	557169	597058	645557	733897
Percentage	42.2	69.0	78.8	62.6	73.1	80.5	85.7
9. T.T. (16 Yrs)							
Target	150000	300000	300000	848600	816400	803363	856000
Achievement	76173	155850	191699	351377	364701	430033	499376
Percentage	50.8	52.8	63.9	41.4	44.7	53.5	58.1

TABLE NO 20

UNDER FAMILY WELFARE PROGRAME IN KARNATAKA STATE
TARGETS AND ACHIEVEMENTS FROM 1986 87 TO ~~1990-91~~ 1992-93

ITEM	1986-87	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93 (P)
STERILISATION							
1 TARGET	350000	350000	325000	311000	360000	345000	360000
2. Achievement	334000	319763	301147	289312	232628	301639	331463
a. Vasectomy	13552	6012	2645	2236	1011	754	544
b Tubectomy	320508	313751	298502	287142	231557	300885	330924
i. Minilap	235261	242320	237173	229069	227514	237257	251240
ii. Laproscopic	82249	70931	61329	58073	54043	63628	79684
percent of item 2 to 1	95.4	91.4	92.7	93.0	78.5	90.0	92.1
percent of 2(b) to 2	95.9	98.1	99.1	99.2	99.6	99.78	99.8
percent of 2(b) ii to 2(b)	25.7	22.6	20.5	20.2	19.1	21.1	24.1
I.U.D							
1. Target	180000	195000	210000	223000	262000	275000	290000
2. Achievement	187542	139765	204693	199555	209501	233910	233058
a. Lippes Loop	24779	21399	20547	841	-	--	-
b. Copper T	162763	168366	183346	198714	209501	233910	233058
percent of 2 to 1	104.2	95.8	97.5	89.5	80.0	84.1	82.1
percent of 2(b) to 2	86.8	98.7	98.8	99.6	100.0	100.0	100.0
C.C. USERS							
1. Target	140000	220000	220000	246000	264630	270000	280000
2. Achievement	178690	209316	223745	223703	231493	255296	265537
percent of 2 to 1	127.6	95.1	101.7	90.9	87.5	94.6	94.8
O.P. USERS							
1. Target	65000	65000	65000	49800	77900	80000	112000
2. Achievement	44732	71999	75008	74249	71924	83401	81004
percent of 2 to 1	68.8	67.8	116.3	149.1	92.3	104.2	72.3

12/2/1994

I Health Inspectors

Health Inspectors Training Centers

1. Mandya 2. Mysore 3. Dharwad

4. Mangalore 5. Gulbarga 6. Bellary 7. Belgaum

Intake capacity per centre 75 x 7
= 525

No. of Under Trained
during the year 1993-94 .. 370
(Women)

II Multipurpose Workers

Five Health and Fw. Training centers

1. Bangalore 2. Mandya 3. Ramanagaram

4. Hubli 5. Gulbarga

Intake capacity 60 per Centre .. 60 x 5 = 300

1988-89 : 168
1989-90 : 247 } 618 Candidates
1990-91 : 203 are Trained.

618

III X-Ray Technician Training

(1) Shimoga (2) Bidar (3) Bijapur (4) Gulbarga
(5) Karwar (6) Hassan.

Intake Capacity Six per centre 6 x 6
= 36 candidates

No. under Trained during the year 1993-94 .. 25 Candidates

AN:
AU: KSCFST
TI: Annual Report(s) 1986-87, 1987-88, and 1988-89.
SO/AD: Karnataka State Council for Science and Technology IISc, Bangalore.
Ab: Highlights the developments in various projects undertaken ~~in~~ by the KSCFST. It covers a ~~wide~~ fields like, energy, industry, agriculture, water, environment, housing and information.

AN:
AU:
TI: Bonded Labour in Nagasandra.
SO/AD: Karnataka Civil Liberties Committee
AB: In this 'fact-finding' Committee's report, light has been thrown on the existence of 77 bonded labourers in N. Nagasandra, a village of Kolar dist. The experience of the teams & the analysis of the problem are discussed.

AN:

Au: A Technical Report prepared by a Working Group

TI: Case Study of Doddagubbi Lake.

SO/AD: Karnataka State Council for Science and Technology
IISC, Bangalore - 12.

Ab: This technical report ~~gives~~ presents a picture of ecological damage wrought by improper use of a wetland — Doddagubbi lake, near the city of Bangalore. It highlights the role of man as a destructor / obstructor to the delicate ecological balance. Some concrete suggestions have been made to restore the tank.

AN:

AU: Weiner, Myron

TI: The Child and the State in India

SO/AD: Oxford University Press.

AB: As the subtitle of this work says, this is about "Child labour and education policy in comparative perspective." A very critical analysis of the primary ~~ed~~ ~~to~~ educational policy of the GOI has been made. As Weiner terms it, what India has is a "politics of inaction." The role of religious groups, the research community, the social activists, the trade unionists and of course the educators has been severely ~~criticising~~ criticised. With a rich comparison from the developed world, Weiner argues that hiding behind the veil of poverty for the absence of compulsory education has no basis.

AN :

AU : ISEC, B'lore.

~~SO/AD~~ : ~~ISEC~~.

TI : Children and Women in Karnataka - A Situational Analysis 1990.

SO/AD : ISEC.

AB : This study presents an overview of ~~focuses~~ on the various ~~programmes~~ aspects of Karnataka like its background, physical environment, literacy and education, disabilities and destitution, ~~Chapters~~ child labour which have a bearing on the socio-economic ~~and~~ conditions of women & children. Chapters on "Nutrition and Health" is of particular importance as it provides relevant data on protein-calorie ~~deficiency~~, inadequacy, severely mal nourished ~~children~~ among pre-school children, ~~etc~~. maternal, infant & child mortality rate etc. It also reviews the MCH programme & its implementation, bringing out the regional imbalances.

AN :

AU : Rajagopalan, P.K and et.al.,

TI : Bangalore Mosquito Control Project-
Master plan. (1987).

SO/AD : Vector Control Research Centre
Pondicherry.

Ab : An ~~brief~~ Overview of the existing organizational setup & strategies for mosquito control has been provided. & reviewed in Chapter 1. The next chapter delineates the ~~strategies~~ Master plan, with description & work plan of the ranges, & criteria for staff development.

3. Health Systems & Services.

1. Sanjivi, K.S and Venkateswara Rao, K. "Government's Ally in Delivery of Health Care." TNVHA News Letter Apr. 1990. Role of VOLAGs in health care.

NUTRITION: 2. Pamphlet. "ಬಡವ ಬಲಾಢ್ಯ ಕೊನೆ ಅಂತರ ಸಮರ್ಪಕವಾಗಿ ವ್ಯವಸ್ಥೆ – ಒಂದು ನೋಟ" Pub. by DAVP.

3. Pamphlet of DAVP. "ಬಡವರಿಗೆ ಅಂತರ ಪದಾರ್ಥಗಳನ್ನೆ ಪೂರೈಸಲು ಒಂದು ಕೊನೆ ಸುಭದ್ರ ವ್ಯವಸ್ಥೆ."

4. DAVP Pamphlet. ಶ್ರಮಿಕರು ಜನ ಬಡವರ ಜೀವನದ ಗುಣಮಟ್ಟ ಹೆಚ್ಚಿಸಲು ಯೋಜನೆಗಳು. (See Cover No. 1).

Immunisation:

5. Vasundhara et.al., Vaccination Coverage Survey Bangalore (Rural) District.

6. Vasundhara et.al Vaccination Coverage Survey Bangalore (urban) District.

7. "Primary Health Care Development Systems." A GOK publication.

(3b). - @ - HSSS.

8 16. "Proceedings of the National Conference on Evaluation of Primary Health Care Programme. (Esp. the Article — "Mallur Health Co-operative & Evaluation of PH care" (Session II) by Ravi Narayan & Mahadevan

9 17. IMR Study.

"Home Management of Diarrhoea in Rural India — Report on knowledge, Attitudes and Practice."

10 18. Project Report. (IISc).

"Air pollution and Incidence of Morbid Conditions in B'lore City."

11 19. Karnataka — State of Environment Report. 1983-84.

12 20. Narayan, Ravi

"Dairy As an Instrument for Rural Devb."

13 21. ~~Rein~~ Kavita Rehna

"Reaching out To working children" MADHYAM, 1991.
(At the role of a VOLAG → TC for WC)

14 22. Rosario, Anselm & Chanraj, Kalthyayini.

"Garbage Disposal: Where waste is it Anyway?" MADHYAM III 1991.
The role of an NGO - WASTE-WISE.

15~~23~~. Kallikath, Mani
"Health Care Facilities: No Healing Touch."
MADHYAM III 1991.
Provides useful ~~data~~ statistical data on the availability of mobile dispensaries, PHC subcentres, Maternity homes, UFWCs etc. Also an insight into the health status & working of health care units on the slum dwellers of Bangalore city.

16~~24~~. Narayan, Ravi.
"Towards a People-Oriented Alternative Health Care System."
SOCIAL ACTION, Vol. 39 Jul-Sept. 1989.
This is a plea for participatory basis in health care system rather than beneficiary oriented. To evolve this 'new vision' ~~&~~ there should be a holistic approach, says the author. And not just the imitation of a successful venture one even an amalgam of ~~it~~ various productive initiatives.

17~~25~~. Tekur, Sirdi Prasad.
"Rational Therapeutics"
PHYSICIANS UPDATE VOL III, NO. 4.
A brief note on the present chaotic situation in the field of drug policy, irrational prescriptions by practitioners & people, and attempts at rationalisation, with useful information.

3A. Health Policy.

1. Varundhara, M.K
   "Overall View of National Health Policy."
2. Kulakarni, M.V & Prabhakara, G.N.
   "View of People's Representative in NHP."
3. Thakur, Sivdi Prasad
   "NHP Statement - 1982
   From the Viewpoint of Voluntary Agencies."
4. Narayan, Ravi
   "Some Policy Reflections in the Context of
   (a) Health Policy for Karnataka
   (b) Perspective Planning for Health Services.
   (c) Approach Document for VIII plan."
5. ~~Venk~~ Rao, Venkateswara, K.
   "An Appraisal of the Impact of Eight years of NHP."
   TNVHA Newsletter, July '90.

Ask for Report of the NHP Workshop.
T. Neerajakshi.

3. Health Systems & Services.

Health Edn.

1. Report on "Interpersonal Skills in Hospital & Health Care Administration."

2. Pamphlet: "Medication as a Substitute for Caring."
(No. 1 & 2. Ref. F. No. 73).

NHP.

3. Vasundhara, M.K.
"Overall View of NHP."

4. Kulakarni, M.V & Prabhakara, G.N.
"View of People's Representative in NHP."

5. Tekur, Shirdi Prasad
"NHP Statement - 1982
From the View Point of Voluntary Agencies."

6. Narayan, Ravi
"Some policy Reflections in the Content of
(a) Health policy for Karnataka
(b) Perspective planning for Health Services
(c) Approach Document for VIII plan.

7. Sanjivi, K.S and Venkateswara Rao, K.
"Government's Ally in Delivery of Health Care."

8. Venkateswara Rao, K.
"An Appraisal of the Impact of Eight years of NHP."
(No. 7 & 8 : TNVHA News letter. April & July '90).

9. "Locked in Files – our NHP."
(~~from~~ In "Fellow Traveller, Jul-Aug'91).

Nutrition.

10. Pamphlet.
"ಎಡೆ ಬಡಿಸಿದ ಹೊಸ ಆಹಾರ
ಸುರಕ್ಷಿತ ವ್ಯವಸ್ಥೆ – ಒಂದು ನೋಟ." (DAVP).

11. Pamphlet (DAVP).
'ಎತ್ತರಕ್ಕೆ ತಕ್ಕ ತೂಕ ಇದಾಗಲೇಬೇಕು
ಪೌಷ್ಟಿಕಾಂಶಗಳು ಒಂದು ಹೊಸ ಸುಭದ್ರ ವ್ಯವಸ್ಥೆ.

12. Pamphlet. (DAVP).
ಶ್ರೀಮಾನ್ ಬಡಪಾಯಿ ಜೀವನದ ಪುನಾವರ್ತನೆ
ಸುಧಾರಿಸಲು ಏನೇನು ಮಾಡಬೇಕಿದೆ.

(No. 8 – 12. Ref. Cover No. 1).

Immunisation.

13. Vasundhara et. al.,
"Vaccination Coverage Survey
Bangalore (Rural) District.

14. Vasundhara et. al.
"Vaccination Coverage Survey
Bangalore (urban) District.

PHC. 15. "Primary Health Care System
Development."
A GOK Publication.

4. Indigenous Systems of Medicine.

1. Proceedings of
National Convention on Traditional
Medicine and MCH. (1989).

? 2. Kakar, D.N.
"Primary Health Care and
Traditional Medical Practitioners."

3. Tekur, Sirdi Prasad
"Alternative Health Care Systems:
Another Point of View."
MADHYAM, Apr 1991.
A note on the significance of
non-Allopathic medicine in India.
Provides a statistical idea of
health resources in India (1988); and
~~the role of media in~~ some general
features of mass media inputs into
health issues are touched upon.

4. Tekur, Sirdi Prasad.
"Traditional Medicine."
Background Paper prepared for FGVORD-K
General body meeting at Belgaum,
17-18 May 1990.
Provides elementary information about
the ~~Trad~~ non-allopathic health care
system prevalent in India. It also
examines its relevance, accessibility
& what one can do for its promotion.

5. FW & MCH.

1. Dept. of H & FW Services, B'lore.
"A brief Note on Maternal and Child Health Service in Karnataka State."

2. State FW. Bureau
"Gist of important schemes of FW Pgms for Financial Asst. to VOLAGS."

3. "Voluntary organisations – Their Role & Participation in the FW Pgm."

4. "Scheme of 'mini Family welfare centres' As A Model for Under Innovative Scheme of Grant in Aid Asst. to VOLAGS for promotion of MCH, Immunisation, & Small Family norm."

5. "ಮಹಿಳಾ ಕಲ್ಯಾಣ ಕೇಂದ್ರಗಳು ಧನಸಹಾಯ-ಸಹಿತಯೋಜನೆ ಸ್ವಯಂ ಸೇವಾ ಸಂಸ್ಥೆಗಳ ಪತ್ರ."

(No. 1 to 5. See File No. 73)

6. ISEC.
"Children and women in Karnataka – A Situational Analysis 1990."

7. Ministry of H & FW (GOI, 1987).
"Maternal and Child Health Issues & Interventions."

8. VHAI. (1989-91).
"A project Report – Improved Infant Feeding Practices."

9. UNICEF
"ICDS – An Assessment."

10. Proceedings of
National Convention on
Traditional Medicine and MCH.

11. HEALTH ACTION.
MCH. (Spl. Issue). (1990).

12. "Diarrhoea in Rural India." – South Zone.
A Nationwide Study of Mothers and practitioners.

13. Sahni, Ashok (Ed). (Pub. ISHA).
"Health of Women & Children for Development."

14. "Advertising & Children."
MADHYAM, June 1990.

15. "ICDS – A Study of Some Aspects of the System."
A Projects Report of NFI.
Focuses mainly on the training of AWWs, the relation between AWs & PHC set-ups and the likely impact of the introduction of drugkits on the work of AW in 16 States of the Indian Union. References to ~~there~~ ~~Can~~ Karnataka in this Context can be seen.

(5b) Toiling Children.

(List of Sources).

1. "Editorial", D H, Apr. 24, 1989.

2. Naidu, U.S & Kapadia, K.R (eds)
"Child labour and Health"
TISS, 1985.

3. Rao, R.
"Children of Darkness"
Sunday Herald, Aug. 24, 1986.

4. Mukherjee, S & Pandya Pushkar (eds).
"Child Labour in India."
Proceedings of a Seminar,
Gandhi Labour Institute, 1985.

5. Patil, B.R
"Working Children in Urban India"
D.B. Publishers, Blore. 1988.

& (Nos. 1 to 5. Compiled from

"The Implications of Public policy on Health Status & Quality of life."
Module : II. Case II. 2.
Faculty leader Ram Ghosh).

6. Health Education.

1. Workshop on "School Health and School Health Education."

2. Dept. of H & FW. Pamphlet on "Bureau of Health Education & Training."
(No. 1 & 2. See F. NO. 73).

3. Report on "Interpersonal Skills in Hospital and Health Care Administration."
(Ref. F. NO. 73).

4. Ghosh, Basu. (1991)
"The utilisation and productivity of Health Manpower."
(A case study of a Karnataka PHC).

? 5. Paramedicals Training in India.

? 6. Attitudes Dental Education and Dental Public Health in developing Countries:
A Symposium.

7. IIM Bangalore. (1982).
"Evaluation of "Traditional Birth Attendants (Dais) in the State of Karnataka."
Ref. Bib. Ch 2 (C).

8. Kavita Ratna
"Reaching out to working Children."
MADHYAM, APRIL 1991.

9. Narayan, Ravi.
"An alternative Vision of Education for Decentralised Health Care."
(Workshop paper for NIAS)
A Positive ~~Critic~~ Critic of NHP has been undertaken, in view of the need for a Community oriented medical education (of both the doctors & para-medics). In lieu of this few recommendations - 'positive initiatives' have been listed under issues like Community education, primary education & health, basic manpower training etc. An overview of alternative educational experiments in India & some socio-economic issues pertaining to the health education has been viewed.

~~The~~ Note on "The Paradigm Shift" ~~is a result for~~ provides an 'alternative vision' for health education in India.

10. Narayan, Ravi
"Making Medical Education - A Student's point of view."
Ind. Jour. Prev. Soc. Med. Vol. 4 June '73.
Short-comings of the 'present' system and a few changes needed are highlighted.

9. Women & Health.

1. Pamphlet. (DAVP).
   ಹೆಣ್ಣು ಮಗು ಬೇಕು.

2. "Media and the Girl Child: Strategies to Effect Change."
   MADHYAM. A report on the workshop held on Dec 20, 1990.
   Mainly touches upon the survival & health of the girl child, education and at work.

3. Tekur, Sirdi prasad.
   "Injectable Contraceptives."
   PHYSICIANS UPDATE Vol. III No. 3.
   Takes a look at the controversy raised by the India's modern contraceptive technology. Taking a realistic outlook at the present & socio-eco conditions of India, FP clinics in India, the article pleads for 'rationality, before embarking on questionable & controversial methods. 'Development — the best contraceptive' says the author.

13. Disabilities.

1. "Activities of the Directorate of Welfare of Disabled in Karnataka."

2. Kumar, Jagadish S.A.
"Speech & Hearing problems and Rehabilitation."
(No 1 & 2. Ref. VHAK files).

Lancaster.

3. Vasundhara et. al.
"Vaccination Coverage Survey Bangalore (Rural) District."
"Vaccination Coverage Survey Bangalore (Urban) District.

4.

14. MENTAL HEALTH.

1. Jain, Sanjeev.
"Mental Health Care : A Depressing Scenario."
MADHYAM III 1991.
~~Studi~~ Notes the relationship between Psychiatry & poverty; pressures of Urbanisation, the effects of pollutants; the need for cushions against stress & what is available; insufficient provision of psychiatric care and what the priorities should be - with the city of Bangalore in mind.

2. Isaac, Mohan K.
"Perceptions of Mental Health."
MADHYAM Apr 1991.
Deals with mental Health and the media.

3. Krishnamurthy, Uma.
"Ill Effects of TV advertising on children and the toll it takes on mental health."
MADHYAM, June 1990.

4. Paramesh, H
"Impact of TV viewing on Children & Adolescent Behaviour."
MADHYAM, June 1990.

5. Khan, A.M
"TV & the Child"
MADHYAM June 1990.

15. Panchayat Raj.

1. Chandra Shekhar, B.K
"Political and Administrative Decentralisation : The Karnataka Model."

2. Nagaraj, G.V
"Panchayat Raj and Health Care Management."

3. ~~Narayan, Thetna.~~
"Health.

3. Rudramoorthy, B.
"Suggestions for the Concept Paper on Panchayat Raj."

4. CMC.
"People's Involvement in Planning And Implementation Process."

5. "Karnataka and India at a Glance".
(A Statistical profile as on 31/III/89.

(No. 1 to 5. See File No. 84).

ROLE of MEDIA: 16. ~~20~~. HEALTH AWARENESS.

1. Kavita Rekha
"Reaching out to the working Children"
MADHYAM APR 1991.

2. "Health For All: Role of the Media"
MADHYAM Apr 1991.
About 15 articles, focusing mainly on Karnataka are published in this issue.

3. "~~Advertising and Children~~."
MADHYAM June 1990.

M-I. HOUSING.

1. Prakasa Rao VLS & Tewari VK
"The Structure of an Indian Metropolis: A Study of Bangalore."
Allied Publishers, New Delhi, 1979.

~~2 Singh, H.~~
~~"Strategies.~~

2. "On growing needs of Urban health management."
ISHA, 1986.

3. Rao VLS Prakasha
"Urbanisation in India."
Concept, New Delhi, 1988. (Ref. to B'lore).

4. Dhadave, M.S
"Sociology of Slum"
Archives Books, New Delhi, 1989
(Ref. to Gulbarga).

5. Del, B.C, Sircar, B.K etc.
"Studies on Interventions to Prevent cholera transmission in Urban Slums."
Bulletin of the WHO, Vol. 64, No. 1, 1986.
(Ref. to Gulbarga).

6. Sowanders, C.
"Are Slums here to Stay?"
Sunday Herald, June 15, 1986.
(A Critique on Slum clearance policy by Urban)

7. Rattanani, J
"Bombay Slums: No Easy Solution."
DH, May 29, 1989.
(Contains ref. to the work of Karnataka Slum clearance Board.).

8. Karnataka Slum clearance Board:
Functions and Achievements 1975-86.

9. Reddy, A.M
"Environmental Improvement of Urban Slums: Madras Experience."
NAGARLOK Vol. XX No. 1, JAN-MAR 1988.

~~10~~ [Nos. 1 to 9 compiled from
* "The Implications of Public Policy on Health Status & Quality of life."
Module: III. Case III.1; case III.2].

~~10. Babu Ghosh.~~
~~"The Temple"~~

10. Achar, K TV
"Housing: Going Through the Roof."
MADHYAM III 1990 1.
An analysis of the chaotic growth of the City of Bangalore. Provides projections about the housing, investment requirements, and a percentage division of households on the basis of monthly household income. A Critique of BDA's Planning & Regulation Schemes is also done.

M-II. Urban Crisis.
(Lack of Infrastructure).

1. Bhaskar, B R P.
"Bangalore: The Exploding Urban Crisis."
MADHYAM III 1991.
Briefly touches on the unplanned growth of the city.

2. Bhargavi Nagaraja
"City Planning: Chaos Unlimited."
MADHYAM: III 1991.
A note on the lot of Urban poor.

3. Holarnkar, Samar
"Urban Transport: A Tangled Nightmare."
MADHYAM III 1991.
A note on the ailments of transport system and 'bureaucratic snarls.'

4. Chandy, Nomita and Bhasker, Hinda.
"Water: The Vanishing Resource."
MADHYAM III 1991.
Presents a gloomy picture for the thirsty city of Bangalore.

5. Rosario, Anselm and Chamraj, Kathyayini.
"Garbage Disposal: Where Waste is it. Anyway?"
MADHYAM III 1991.
Takes a look at the 'other' side of the 'Garden City' (B'lore) and provides some useful data. Also focuses on the work of NASTI-WISE.

6. Alur, Manvel.
"Energy : Fuelling the Urban Crisis."
MADHYAM III 1991.
Focuses on the energy consumption patterns of the urban poor, with adequate data.

7. KSCST
Annual Reports (86-87, 87-88, 88-89)
On energy, ~~industries~~. water, housing

8. "Case Study of Doddagubbi Lake."
A technical report prepared by the working group of KSCST.
On the improper use of water usage.

M III

1. "Case Study of Doddagubbi lake."
A technical report prepared by a the working group of KSCST.
On the ecological imbalance brought out by man, esp. because of bad agl. practices.

2. ~~Subba~~ KSCST.
Annual Reports. (1986-87, 87-88 & 88-89).
Covers research developments in the fields of energy, industry, agriculture, water, environment, housing & information

AN:
Au: Tekur, Shivdipprasad & Gopinath.
Ti: Health Status in a Tibetan Settlement. (1988).

So/AD: CHC.

Ab: "A report of a participatory reflection on the 'Community Health' dimension of the existing & ongoing health programmes in the Tibetan settlements in Karnataka State particularly, the Doegubling settlement in Mundgod."

AN:
Au: Narayan, Ravi
Ti: Health, Nutrition and Agricultural Development-
(An exploration focusing on Karnataka State). (1987).

So/AD: CHC.

Ab:

DEEDS DIALOGUE.

1. AN:
AU: Workshop Report.
TI: Structural Analysis of South Kanara.
SO: DEEDS DIALOGUE No. 22, Dec '83.
AD: Development Education Service
Lower Bendur, Mangalore - 575 002.
Ab: Imp. changes underway in the ~~dis~~ fields of economic — agriculture especially, the standard of living, social & political situation of South Kanara district has been dealt.

2. AN:
AU: ~~A Project Report~~ Margaret & Merlyn
TI: The Beedi Rollers of South Kanara.
SO: DEEDS DIALOGUE No. 28, Jun '85.
AD:
Ab: A ~~brief~~ short impressionistic study on the ~~situation~~ living conditions of Beedi workers. ~~in South~~

F.No.25

AN:

AU: ISSAC, M.K.

TI: Severe Mental Morbidity.

SO/AD: ICMR Bulletin Vol. 18, No. 12 Dec '88.

Ab: A comparative perspective on the prevalence of severe mental illness. The focus is on psychosis & epilepsy. The four centres studied were in the districts of Vellore, Baroda, Calcutta & Pondicherry.

AN:

AU: Recommendations made by the Central Council of H&FW in its meeting held on 19-20th Aug, 1982.

TI: National Mental Health Programmes for India (1982).

SO/AD: Ministry of H&FW.

Ab: After taking a look at the current status of mental health in India, the report spells out the objectives of the NMH Prgm. And delineates the proposed plan of action.

AN:
AU:
Ti: NOTE ON ICDS (As on 1/10/89).
So/AD: Directorate of Women and Children's Welfare, Orissa.
Ab:

AN:
AU: Rita Mukhopadhyay. (F.No.25A)
Ti: Methods Against Madness
So/AD: Sunday Herald, Nov. 8, 1981.
Ab: A report on the alternate method adopted by NIMHANS to treat the people suffering from mental illness, worked out in 120 villages of Orissa Dist.

AN:
AU: Madhvani, Nrupen.
Ti: The Possessed.
So/AD: Sunday Standard Magazine, May 10, 1981.
Ab: Report on the Gonagopur — where possession ~~of spirits~~ takes place ~~regularly~~ during every March.

F.No.30.

AN:
Au:
Ti: The Feeble Voices from the forests
So/Ai: JANASHAKTI, Jan 1992 Vol.2.No.1
FIDINA, 902 Indiranagar I Stage
B'lore 38.

Ab: The article focuses on the plight of the tribals of H.D.kote and Coorg districts of Karnataka. The focus is on the landless tribal groups (HADIS), the displaced and on the farce of rehabilitation.

Au; Vasu
Ti: Sustainable farming
So/Ai: JANASHAKTI, No 3&4/1991 (Feb) Jul/Sep 1991.
FIDINA ...

Ab: A reports on the tribals of H.D. Collective farming, taken up by the tribals of H.D.kote. Marti Hadi at H.D.kote. In keeping with the The collective farming was in form of Organic farming.

F.No. 16A.

Ti: The Memorandum on Emergency Medicine Submitted to the GOK.

So/An: IMA FOCUS M.9.
Monthly Journal of IMA-K branch
Alur Venkata Rao Road, B'lore-18.

Ab: Text of the Resolution of the IMA opposing the Govt's move to introduce an 18 month "Emergency Medicine" course to the Students of Ayurvedic & Unani System of medicine.

Au: Parameshwara, V

Ti: Declining Standards of Medical Education Deplored.
Speech delivered at the 49th Karnataka State Medical Conference at Chitradurga on Oct 9, 1982

Vol. 1, Issue 7, 21-10-1982.

So/An: IMA focus pp. 2-4 & 13.

Ab: This Annual report by the outgoing President mainly focuses on the falling standards of medical education and emphasises the need for holding refresher courses to the practising doctors.

AU: Rajagopal, B.V

TI: Call to make best use of Doctors.
Presidential Add. at 49th Kerala State Med. Conf.

SO(AD): IMA focus Vol. 1, No. 7, 21 Oct 1982
Pp. 5-7 & 10-11.

...

Ab: Doctors are unlike the missionaries who are provided with basic facilities. Private doctors are nothing by earning money. But stringent regulations by IMA is necessary, apart from the steps taken by the GOK. A plea against mushrooming of medical colleges is also made.

AN:

F.No.37.

AU: MEGNA, C.K.

Ti: Delhi for the Disabled (I to V).

ISO: "37.

SO/AD: Karnataka Scope", Deccan Herald Saturday July 28, Aug. 4, Aug. 11 & Aug 18, & Aug. 26, 1990.

Ab: In this series of articles carried on every Saturday, the author takes a look at the rehabilitation of disabled taking place in the state of karnataka. Drawing attention to the work of a few VOLAGS, this article examines the novel schemes & nagging problems of rehabilitation in karnataka, with education.

1. AN

AU: Isaac, Mohan. K

TI: District Mental Health Programme at Bellary.

SO: Community Mental Health News Nos 11 & 12, April - Sept - 1988.

Ad: ICMR Centre for Advanced Research on Community Mental Health NIMHANS, Bangalore.

Ab: A comprehensive coverage on mental health care at a district level covering the planning, participation, provision of information & drugs. Statistical data on epilepsy, psychosis, neurosis & mental retardation has been reported.

2. AN:

AU: Shetty, Mamatha & Jayaprakash, M.R.

TI: Solur: Mental Health in Primary Health Care.

SO: Nos 6 & 7, Jan-Jun. 1987.

Ad:

Ab: A brief report on the completion of two years of the project — "Mental Health in PH Care;" a village centre in the Bangalore (rural) district.

AN:
AU: Project Report.
TI: Mental Health in PM Care.
SO: Illness No. 5, Oct--Dec 1986.
~~Ad~~:
Ab: The project report for the first year outlines the study area, available ~~medical~~ medical infrastructure, progress in different phases and useful statistical data on ~~diagnos~~ no. of mental illness cases, etc.

AU: Prabhu, G.G.

TI: ~~Mental~~ Handicap in India — A Situational Analysis.

SO/AD: AADN Vol. 1 No. 1, 1993.

~~AD: Prof & Head of Clinical Psychology~~
~~NIMHANS Bangalore - 29.~~

Ab: Refers to Some ~~various~~ studies conducted in Karnataka on ~~the~~ of mental retardation in children and provides few statistical data.

AU: Bajpai, Asha

TI: The Disabled and the law.

SO/AD: AADN, Vol. 2 No. 2 1991.

~~Ad:~~ Research Associate
National law School of India University
Central College Campus
B'lore - 1.

Ab: ~~It~~ ~~A brief~~ various legal ~~Acts~~ provisions governing the policies & rights of the disabled people has been Overviewed.

AN

AU:

TI: CBR projects of the Disability Division.

SO/AD: AADN, Vol. 6. NO. 1 1993, Supplement.

AB: A (cursory) look at the programmes conducted in various parts of Bangalore and KGF by the AAI in its Community Based Rehabilitation project has been given.

Action Aid Disability News.

1. AN
AU: Krishnaswamy, Rukmini
TI: Work Training for people with Disabilities – A perspective in Reverse.
SO/AD: Action Aid Disability News
Vol. 4, No. 2 1993
ActionAid India 3, Rest House Road, Bangalore-560001.
~~Ad:~~ Director – Technical Services
Centre for Special Education
Spastics Society of India
No. 31, 5th Cross, V Main
Indiranagar I Stage
B'lore – 38.

Ab: Provides information about the employer's expectations of disabled person's social & academic skills; Consumer's preference ~~index~~ for services which the disabled can give, and the occupational status of the disabled. Their view of their rehabilitation.

AN:
AU: Pruthvish, S and others.
TI. Identification and Needs Assessment of Beneficiaries in Action Aid India Supported CBR Projects – Some Preliminary Reflections.
SO/AD: AADN
Vol. 4, No. 2 1993 Supplement.

Ab ~~50~~ : The ~~prelim~~ Community based
~~AA~~ : rehabilitation programme of the
~~A5~~ A.A I has been assessed, conducted
in different states, including
Karnataka. The different tables
provide a very good ~~Comparitive~~
data — of Karnataka & other states
and also that of Karnataka &
a few developing countries.
The data covers prevalence
rates of disabilities, prevalence
of different types of disabilities etc.

AN :

AU :

~~TI :~~ ~~Proceedings of a~~

TI : Government and Voluntary Agencies in Karnataka. (1985)
Proceedings of a Two-Day Dialogue.

SO/AD : FEVORD-K.

AB : This ~~preamble~~ small booklet provides an insight into the the expectations and evaluations on part of the both Government and the VOLAGS to work together with the rural poor, on programmes of common interest.

Government's welfare programmes like the Social-forestry, ~~Progr~~ IRDP, family welfare, NREP, RLEGP, Mahila Mandhyal and ~~the~~ ICDS. The case study on NEGRU NIRVAHANA SAMITHI of Nelamangala, Bangalore district provides a new model.

AN:
AU: KALLIATH, Mani
TI: Project on Factors Affecting the Health Situation of Slum Dwellers of Bangalore. (~~Jan~~ July ~~July~~, 1990).
S/AD: Community Health Cell
326, V Main, I Block
Koramangala
Bangalore - 560034.

Ab: Bangalore, growing in a very ~~fast~~ pace is beset by the problem of ~~urban~~ slums. The health status of the residents of these 'notified' and 'unrecognised' slum dwellers ~~is~~ has become the new focus of interest on the project.

Ab: This survey reports a conducted ~~over a period of~~ from Jan to Jun 1990. ~~For~~ The introductory chapter delineates the broad scope of the study. Methodological issues are discussed in chapter two. ~~The~~ An overview of urbanisation and ~~its effects~~ urban poverty in the context of India has been briefly dealt in chapter 3. The chapter 4 ~~deals~~ pertains to 'slums in Karnataka', where the ~~actual~~ scenario of the slums, & the working of state agencies has been particularly discussed.

Chapters 5 and 6 analyses the various socio-economic factors affecting the health of slum dwellers, the problems they face, their response and the health care facilities they are provided with, with sufficient amount of statistics collected from primary and secondary sources.

Chapter 7 takes a look at the initiatives of the government. ~~and the author concludes with the.~~

AN:

AU: Rao, Rama S.V

TI: A Report on the Study of Slum Certain Slum Areas of Sheshadripuram, Bangalore-20. (May 5, 1993).

SO: Deena Seva Sangha, B'lore.

Ab: This report is undertaken as a part of assessing the community health project run by the Deena Seva Sangha. Four slums of the Sheshadripuram, Bangalore have been covered.

A statistical profile of the socio-economic status of these slumdwellers has been presented. Also, educational status, the skill level of the dwellers, sanitation facility, housing, lighting, morbidity pattern of common illness, the available medical aid, prevalence of leprosy, alcoholism, & smoking, handicaps, family welfare awareness of F/P/Preg, immunisation particulars of under fives, and felt needs have been covered in 37 tables.

AN:

AU: Subbarao, P.V

TI: Survey of Allergy in Bangalore Due to Parthenium.

SO: Laboratory of Immunology and Allergic Diseases
Department of Biochemistry
I I Sc, Bangalore.

AD: Karnataka State Council for Science and Technology
I I Sc Bangalore - 12.

Ab: Highlights the severe allergic rhinitis effect of the Parthenium pollen on the residents of Bangalore. About 7.1% of the universe (n = 2035) showed the allegic effects of being exposed to Parthenium. The survey was conducted during 1984-86. A comparitive study of other common airborne allergens has also been made.

AN:

AU: Aranha, Celine (1978)
TI: Report of The South Kanara District Health Survey.
SO: VHAK

AD: Moras, Rev. Bernard
Director, Fr. Mueller's Hospital
Kankanady, Bangalore.

Ab: This survey is sponsored by VHAI and conducted by VHAK(SK). ! This is a very good beginning to help in the direction of, as the survey report claims, regional planning in health care. Though the methodology results are based on insufficient data, a good productive initiative has been taken.

The survey has tried to cover various the availability of various medical facilities, the awareness among the people about health related activities and the work of Panchayats in the district of South Kanara. Panchayat & health units the work of schools, in promoting health education, taking up preventive & curative measures etc.

An attempt to formulate a Five year plan has also been made.

AN :

AU : ~~Directorate of Health and~~

TI : Primary Health Care System Development.

SO/AD : Directorate of Health and Family Welfare Services Health and Planning (Feb '90

AB : This small booklet has been divided into five parts. Part A deals with the concept of PHCare & philosophy underlying it. Part B, ~~and~~ dealing with PH care and Health care system in the form of question & answers provid are in the ~~form~~ of question & answers format. Part ~~I~~ provides statistical data.

Providing the routine answers the report however admits These deal ~~respectively~~ with the relation between PH care & Health Care System, people's involvement & management, and Health man-power development respectively. Part I provides statistical data.

Doing on the ~~Providing~~ routine answers the report however admits some lacunae like the lack of innovation, weak referral system link, lack of appropriate

technology, inequality in access to PHCDS. And while asserting that there is no lack of Health Man powers & training institutions, the report contradicts itself by stating that "the training of health workers ~~may~~ perhaps may not be meeting the expressed demands of the community."

An:

Au:

Tl: Statistical Report- 1986-87.

So: Department of Health & Family welfare.

Ad: Bureau of Health Intelligence
Directorate of H & FW Services
Bangalore - 9.

Ab: Presents a statistical picture of targets aimed at and those achieved under various govt. programmes. Also that of the health care facilities, the staffing pattern, the institutions - both Indian and allopathic existing in the state etc under ~~the~~ broad four divisions.

AN:

AU: Kekre, M.M et.al.,

TI: Vaccination Coverage Assessment in Chickmagalur District. (1987)

SOURCE: Department of Community Medicine
St. John's Medical College
Bangalore - 34.

AB: ~~This~~ The survey was conducted at the request of the GOK. It ~~assesses~~ covers the planning supervision and monitoring of the immunisation programme, health facilities available, quality of cold chain, health education activities, the KAP of mothers with respect to immunisation. Chapter 6 ~~contains~~ assesses the vaccination coverage. The next ~~three~~ chapters deal with other findings like ante-natal care, source of I dose of DPT and OPV & personnel in attendance during delivery. Chapters 8 and 9 lists out the reasons/obstacles for failure of immunisation and some comments and recommendations.

Annexures I & II presents a picture on KAP of the health workers & ~~the~~ medical officers.

AN: Dr. Vasundhara et al; (Jan, 1991).
AU:
SO/AD: Bangalore Medical College
Dept. of Preventive & Social Medicine.

TI: Vaccination Coverage Survey
B'lore (Rural) District.

AB: This survey covering about 80 clusters of the Bangalore (Rural) district provides useful statistical information about Vaccine Preventable Diseases; A part of UIP Survei-lance programme of ICMR. A Comparitive study has been made to Cover the percentage of immunisation among the mothers & children, & the drop out-rates; infant coverage, lameness survey (due to polio etc.,) and a neonatal tetanus survey has also been conducted. The survey report also throws light on the various reasons for drop out rates An evaluation of "Cold chain" and ILR has also been made. A few general recommendations has been made. A significant point arising from the study is that mother is the usual decider with regard to immunisation. despite the low level of knowledge about the preventible diseases.

AN:

AU: Dr. Vasundhara et al., March (1991)

TI: Vaccination Coverage Survey Bangalore (Urban) District.

SO/AD: 1) ~~Dpt. of Preventive~~ Bangalore Med. College
1) Dept. of PSM.

AB: This survey of B'lore (urban) district is a part of UIP Surveillance Programme of ICMR. ~~Like it~~ 30 clusters were selected ~~from~~ for the study in Bangalore (urban) district.

It focuses on MCH, restricted to various Vaccine~~tion~~ preventable diseases like polio, tetanus etc, and the reasons for drop out rates/ immunization failure, and the source of immunization. A comparison with the reported coverage has also been made. Two significant points emerging from the study are, ~~that~~ (i) the knowledge about diseases prevented by immunization is low and, (ii) the decision to immunize was mostly made by the mother.

AN:

AU: Mani, K.S and Srinivasa Murthy, H.K

TI: Handigodu Syndrome - A peculiar Orthopaedic problem.

SO/AD: NIMHANS, Bangalore - 560 027.

AB: A medical report on the investigation carried out in the Malnad region, which is affected by this peculiar problem. It gives the. Apart from presenting the results of various tests conducted, the history of the region, dietary habits and activities of daily life have been recorded.

AN:

AU: Report of the a team of National Institute of Nutrition, Hyderabad.

TI: Handigodu Syndrome (Endemic Familial Arthritis).

SO/AD: ICMR Bulletin: Vol.7, No.6, Jun 1977

AB: This epidemiological report focuses on the "Balapura Syndrome", or "Mystery Disease" or "Handigodu Syndrome." A look at the agricultural practices and food habits of the people of the affected area has also been made. Study of non-affected neighbouring areas has also been reported.

AN:
AU: Nuruddin, Muhammad et.al.
TI: Report of Investigation Team of Experts on Handigodu Syndrome in Shimoga and Chickamagalur Dist.
SO/AD: Directorate of FW Services, Blore-9. (1983)
Ab: This medical report studies the reasons for the outbreak of HS in the Malnad part of Karnataka. A The pedigree of the persons affected by this peculiar disease has been made along with other medical procedures, & food habits.

AN:
AU: Ayyoth, P.V and Sudarshan, M.K.
TI: Handigodu Syndrome — A mysterious Disease.
SO/AD: Karnataka Medical Journal Vol. XLVIII, pp 103-07, April-Jun, 1983.
Ab: A profile of the Handigodu Syndrome and a few suggestions have been given.

AN:
AU: G. Rao, Gundu, N.C
TI: Disease that Seeks out Scs in Handigodu.
SO/AD: Sunday DH, Apr. 10, 1988.
Ab: Highlights the socio-economic bias of the Handigodu Syndrome with few interesting case studies and the vol. efforts being undertaken for the relief of the affected.

AN:
Au: Karanth, Shivaram
Ti: Mangana Kaile.
Lan: (Kannada)
So/Ad: Sadashaya Prakashana, Mundaje
Dakshina Kannada -- 574 228.

Ab: This small booklet in simple kannada delineates the general symptoms, reasons and the precautionary measures to be taken for the Mangana kaile or Cassanoora forest disease.

AN:
Au: Dairlla, Shama Pa (Ed)
Ti: Mangana kaile Unnigalu mattu Hatthati.
Lan: Kannada
So/Ad: Sadashaya Prakashana
Mundaje
D K - 574 228.

Ab: The main carrier of Cassanoora forest disease or the Mangana kaile, Unnigalu (Hanna Physalis (?) Spinejera) is the subject of this book. It gives out the life & growth of and the control measures to be taken to destroy unnigalu.

AN:

AU: Bhat, H.R

TI: Mangana kaile | Key Lessons for forest-disease.

SO(AD): SA ...

Ab: Kyasanuru forest disease, unique in its notoriety in India has been dealt. The background of the disease, the reason, how to control the disease, various experiments undertaken to find a vaccine are dealt in this booklet.

AN.

AU: Saksena, T.S & Govindarajulu, P.N

TI: Health Care for Urban Slums with special Reference to B'lore City.

SO: ~~Proceedings of~~ Health Care for the Villages and Urban Slums. Proceedings of the Tenth Annual Conference, 1990.

Ad: ISHA
104(15/37), Cambridge Road Cross
Ulsoor, B'lore-8.

Ab: A brief look at the ~~Slums~~ situation of slums in the city of Bangalore. Work of the govt agencies ~~and~~ disease profile and suggested strategies for health care of slums are dealt.

AN:

AU: ISHA. ~~D.~~ ~~Ach~~ Sahni, Ashok et al.

TI: Nutrition and Health: A Comprehensive Assessment of Programmes for Women and Children in Two Districts of Karnataka.

Feb, 1991. 1991

So. ISHA, 104 (15/37) Cambridge Road Cross, Ulsoor, Bgore-8.

~~Ab~~: A general picture of the programmes for women and children in Karnataka

Ab: This survey report tries to assess various health and nutrition programmes for women and children in Karnataka. The two districts of Gulbarga and Raichur were chosen to assess the impact of the programmes, ICDS, Immunisation programme, Vit A administration, prophylaxis against nutritional anemia in mothers and children, special nutrition programmes, School mid-day meal programme, Subsidy scheme for income generation activities, maternity allowance for agl., landless labourers, creches for children of agl., labourers, & Mahila mandal schemes. The role of Vol. agencies in these two districts has also been considered & found to be inadequate.

AN:

AU: ISHA. ~~Def.~~ ~~Arth~~ Sahni, Ashok et al.

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AN:

AU: Project Report - A Draft Document.

TI: Nutritional problems and priorities of Karnataka: An (1986) Evaluation (1986)

SO/AD: Nutrition Research Centre (ICMR), SJMC, Blore - 34.

Ab: Prot Giving a general setting of the nutrition status of India initially, this draft report tries to make an evaluation in particular of karnataka. Statistical data on various issues related to nutrition has been covered. Like, status of health & nutrition in karnataka, average intake of food stuffs nutrients, infant mortality, IUGM in children, (areawise & CDS covered) diarrhoea in children, percentage distribution percentage of deaths in infancy & early childhood in different districts of karnataka, percentage of malnourished children (1-5 age group) in the four southern states, and also districtwise to karnataka, and specific problems like Vit A def., Vit B complex def., goitre, fluorosis, Kwashiorkor syndrome have been covered.

consumption of different food stuffs perday, nutrient intake, & percentage prevalence of nutritional deficiencies among two tribals — koragas & Soligas of karnataka has also been covered.

AN:

AU: The Institute of Social Studies Trust.

TI: Linking Fertility and the Socio-Eco Activity of Rural women... A Case Study on the Mahur Rural project of the FPAI. (1987).

SO/AD: ILO, Geneva, August-

Ab: A very comprehensive case study.

of ??

Incomplete

AN: Diet. Atlas of India (1971).
TI:
AU: Gopalan, C et al.

SO/AD: National Institute of Nutrition
ICMR
Hyderabad – India.

Ab: Provides valuable data, ~~etc~~, as on 1970-71, about the various salient features of the diets obtaining in our country. In the first part, "Diets in India", information on the population of India & food production in comparison with our requirements is presented. In the second part, "Diets in Different States of India", the pattern of diets in various regions and data on food economics are indicated. The third section is devoted to dealing with the diets of spl. groups of population like the pre-school children, pregnant & nursing women, tribal groups, industrial workers & diets in spl. situations like droughts & famines.

Detailed statistical data on these issues has also been appended.

Is Karnataka mentioned - if so where - and what types of tables are available?

AN:

AU: MARTIN, JOHN D

TI: The Evaluation of the Delivery of Primary Health care. (1977).

So/: A note submitted in part fulfilment
AD of the requirements for the degree of
~~AD~~: MSc in Social Medicine at the University of London. Critical

Report

Ab: An evaluation of 8 PHCs, organised by the Mallur One covered by Co-operative effort and the other two covered by the government, (which were used as controls) in the state of Karnataka. A detailed study of methodology has been been made which is of particular importance to all.

AN:

AU: Project Report.

TI: ICDS – A Study of Some Aspects of the System. (1988).

~~SO: Nutrition Foundation of India.~~

~~AF:~~

SO/AD: Nutrition Foundation of India.

~~Ab~~ Ab: This study tries to evaluate the work of Anganwadi workers from 16 States of India. It focuses on the training they receive.

Ab: This study tries to evaluate some of the components of the ICDS, in order to ~~to~~ see the relevance of ~~drug~~ introducing drug kits to the Anganwadi workers. It covers ~~also~~ 16 States including Karnataka. each taken from 4 different zones. ~~Some~~ of the important aspects covered are the training the Anganwadi workers receive, so as to reorient it ~~for~~ ~~on effic~~ to help the AWWs to be more efficient in their duty; the functional linkages between ICDS & PHC set-ups; and the likely impact on the work of AW by the introduction of drug kits.

An attempt to study the awareness & utilisation of the services of AWO has also been made.

~~Au~~ : ~~Ot~~.

Auth : ~~Bose~~ Ghosh, Basu (1991).

Title : The utilization & productivity of Health manpower. (A Case Study of a Karnataka PHC).

So/AD : IIM, B'lore.

Ann : (i) ~~Study of a PHC~~

(ii) Purpose ~~charted~~ to assess the time utilization pattern & resultant productivity.

~~(iii)~~ (b) to suggest "realistic measures" for successful implementation of PHC(D)~~ys~~.

AB : An in-depth study of a PHC, called "Kunj PHC" (near B'lore). has been made to assess the time utilization pattern and measure the productivity of medical Officers, Senior Health assistants, pharmacist & para-medical worker. The method used is one of non-participant observation & sampling procedure, over a period of 3 months. (Much emphasis on FP Aspects.)

Description of Kunj PHC.

The study shows ~~that~~ a "sex-division" of preference in work towards/ with male health workers from AHO down emphasising the controls of communicable diseases while the female health workers from LHO downwards ~~for~~ emphasise MCH & FP.

Besides
I. It tries to understand the attitudes of Health manpower through "Self-logging" method also. A few Case studies on mal-utilisation of health manpower has also been included and their economic implications calculated.

Summing up with the "Implications for Management" the study concludes that about 33% of the professional health man-power's time (of 360 minutes) is wasted. And a few remedial measures for better management has been suggested.

AN:

AU: ICMR (Ed)

TI: National Conference on Evaluation of Primary Health Care Programmes. — Proceedings of the Conference held at ICMR (Apr. 21-23, 1980).

S/AD: ICMR, New Delhi.

Ab: A very useful compendium of experiences in the PH Care system from all over the country. A fair balance of theoretical issues has also been included.

Divided according to the sessions, the volume covers issues like Comprehensive approach to PHC, Community participation, health man power, components of PHCare & linkages within health system & with other sectors. The last one contains an article on the utilisation of Ayurvedic medical care. The last section is ~~divid~~ devoted to "Evaluation methodologies," which is of particular importance.

The article on "Mallur health Co operative & evaluation of primary health care" (section II) is very useful for those ~~co~~ interested in Karnataka's health status.

(SK)
On the whole a good first effort !!
and we need to complete the first draft typing or type write or WP soon.
Some of the Annotations could have had a little more details so that the readers get a more comprehensive picture of what the report or publication covers

Since the focus was on Karnataka - we should Primarily include reports/publications that mention some aspects of the situation or data on Karnataka. General reports reflections which are written by authors based in Karnataka but not focussed on Karnataka should be mentioned only as a supplementary list as additional supplementary reading

Many Available Reports not included

1. VGKK - Anubhav Series
2. ↓ Tribal Development
3. Health - Agriculture and Development - interaction a Karnataka Case Study (RN)
4. Epidemiology of Mental Illness - A Survey in Karnataka - Mohan Isaac
5. Reports on Mental Health Project of NIMHANS in Bellary
6. State of Indian Health - VIII - Karnataka References
7. NIAS workshop report on Health Services and Panchayatraj

8. 15th - Study on Dens

I discovered that

Some of these

are available later

- following a collection

of links —

There seem to be

some confusion in

the filing - there are

annotations - followed

by links - followed by

further annotations. The

logic was not clear

RN

9/13/94