KARNATAKA

TOWARDS

EQUITY, QUALITY AND INTEGRITY IN HEALTH

FOCUS ON PRIMARY HEALTHCARE AND PUBLIC HEALTH

FINAL REPORT

of

THE TASK FORCE ON HEALTH & FAMILY WELFARE
GOVERNMENT OF KARNATAKA
APRIL 2001

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Towards Equity, Quality and Integrity in Health

Final Report of the Task Force on Health and Family Welfare

ABRIDGED VERSION

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PREFACE

The Task Force on Health and Family Welfare is happy to present this Final Report. It would be recalled that the Task Force had presented an Interim Report in April 2000. It made recommendations therein which, the Government of Karnataka, we are pleased to record, received with appreciation, and more importantly, acted upon. The issues of concern and key messages of that Report have been considered and studied further in greater detail, against the backdrop of a vision for better health in the State. The conclusions of the deliberations on these issues are presented in this Final Report.

At first sight, the recommendations may seem rather detailed, extensive and wide ranging. However, in view of the importance of health as probably the most important element in the effort to achieve an acceptable standard of quality of life for all, the consideration of issues had to cover all aspects of the health services and closely inter-related sectors of development. It is rarely that such an opportunity arises, which permits examination of issues in full of the health services and in conjunction with the sectors that lend these services strength and support. A holistic view of health services as an integral part of the entitlement of the people to basic services has, therefore, been taken. Consequently, this Report has considered the content, quality and reach of health services, and administrative and management issues in the social and economic context of the State.

In the course of examination of the issues relating to health services it has repeatedly become apparent that the key factor that influences the efficiency of these services and ensures the social accountability of the system is the issue of governance. It is apparent that professional skills, financial allocations and departmental infrastructure, important as they doubtless are, can contribute to performance only up to a point. The core issue, however, remains the motivation and commitment of the staff. There is need to nurture the young health professional and other allied health workers, supervising and facilitating them. There is also the need to institutionalise discipline tempered with morale building, peak performance and accountability to the public, together with the involvement of the people in attaining and maintaining their own health. The recommendations on restructuring of the health services have been made keeping these essential parameters in view. It is appreciated that the recommendations call for basic structural changes. They have been made in the full confidence that such changes are not merely desirable, but essential, and would be viewed by those in the system in this light.

It is recognised that the examination and implementation of many of these recommendations by Government would take some time. Others can be implemented without delay, as had been done for the short term recommendations. It is hoped, and indeed urged, that the same sense of urgency and concern on matters relating to health, that induced the constitution of this Task Force, would continue to prevail, and that no time would be lost in establishing mechanisms for implementation of the recommendations. Such a mechanism has been suggested in the Report. Priority in setting up these mechanisms is urged. As responsible and responsive persons, the members of the Task Force would be happy to contribute their expertise in this effort. As an effective measure for implementation of these recommendations and for monitoring implementation and generally to further the objectives of rapid improvement of the health services, the early constitution of the Commission on Health recommended herein is urged.

The Task Force has attempted to cover as much ground as possible. However, it need hardly be emphasised that many aspects would still need consideration. At best, what has been presented is a detailed blueprint. This

would have to be built upon by those who constitute the health services and, therefore, have direct functional responsibility. In fact, one looks forward to an internalisation of the recommendations and their improvement by those within the system. The Task Force had numerous occasions to have detailed discussions with members of the Health Services at various levels and exchanged ideas and views freely. We look forward to their active and total involvement for quantitative and qualitative improvement in the system. This would be the test of total acceptance of the need for change, and change at a quick pace.

The recommendations made therein have been welcomed enthusiastically and many of them have been implemented by the Government in a short span of time. This response evokes confidence in the Task Force that the recommendations made in this **Final Report** would be implemented in the same spirit in which they have been made, namely of concern for the health of the people of the State and their welfare. Once these recommendations are implemented, the health services in the State will achieve both professional competence and efficiency of a high order, with equity, so as to serve the people of the State to their full expectations, contributing to the enhancement of their quality of life.

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ISSUES OF CONCERN AND AN AGENDA FOR ACTION

Over 14 months, the Task Force on Health and Family Welfare, Karnataka has had the benefit of a very wide range of interactions and discussions with a large number of health care providers, decision makers, policy makers, representative of professional associations, voluntary and private sector health care organizations, elected representatives of the people, representative of citizens groups and the community. These discussions were open and frank, in a sprit of dialogue and very constructive. Concerns were shared and suggestions and ideas to improve the health care system in Karnataka were freely given. Many of these have been included in the different chapters included in the final report.

There are some major concerns and cross cutting themes that affected all aspects and sectors of health care. These need to be tackled on an urgent and sustained manner through what we have suggested as an Agenda for Action. Many of these factors are not specific to the health care system itself. They are also problems of the larger society within which our efforts in health care are located. Therefore they impinge and distort our efforts to evolve a health care system that is committed to **equity, quality and integrity** with a special focus on **primary health care** and **public health**. We need to tackle them seriously.

1. Corruption

Throughout the discussions, the task force was informed through a wide variety of sources of the widespread and growing 'corruption' at various levels of the system and in all aspects and sectors of health care. This took many forms.

- **Monetary considerations for appointments, promotion and transfer.**
  (Every level had a price and a hierarchy of amounts depending on importance of job.)
- **Corruption at the time of selection of candidates for educational institutions / programmes and at the level of examinations.**
  (The process had become so vitiated that students are now paying not to pass but to prevent being failed. Even awards and distinctions had a price.)
- **Monetary factors distorting access and utilization of health care services at different levels.**
  (Whether it is a charge for a sputum cup for a tuberculosis patient, or to get facilities in an urban or rural health centre; or taluka hospital for an emergency surgery; or even just to see a newborn baby in a corporation hospital with rates for male babies exceeding that for female babies! Monetary demands for routine services that are supposed to be free are rampant).

While such widespread corruption is nowadays often passed off as a worldwide phenomena; or as being linked to our political system and its funding mechanism, and so on, it is essential that the leadership of the state at all levels be committed to tackling this problem and **move actively towards a zero-tolerance level.** We have particularly been encouraged at steps including counselling during recent appointments made after the Interim report, during which monetary transactions did not play a role.

Agenda for Action

a. We suggest a 'vigilance system' in the directorate and health ministry that will monitor and help

proactively counter this widespread problem. (See section on Administration) We believe there is already political and bureaucratic will, as demonstrated by decisions taken on our interim recommendations and by the recommendations of the Administrative Reforms Committee.

b. *We also suggest that senior leadership of the health care system should discuss and monitor this issue so that a new climate against corruption is built up proactively at all levels.*

2. Neglect of Public Health

There is an overall neglect of public health principles and practice in planning, organisation and management of health care services, and this has shown worsening trend. The neglect is symbolized by

- Inadequate emphasis on tackling the determinants of ill health particularly **nutrition, water supply and sanitation, housing, literacy and poverty alleviation,** which are crucial to public health and were even identified as early as in 1946 in the Bhore committee blue print that was accepted by independent India as a framework for health service development. Further by compartmentalization of the ongoing efforts in these directions by different departments and ministries, the intersectoralilty of all these with basic health has been lost.
- The key to good public health is a robust **health information system** which monitors both the health status indicating problems and health care inputs and outcomes, supported by an efficient epidemiological, microbiological and entomological surveillance system. Inspite of so many projects and programmes, the quality, reliability and scientific validity of all the data that is being routinely collected and published leave much to be desired, it is another aspect of this overall neglect.
- The overall lack of emphasis on **preventive, promotive and rehabilitative care,** except perhaps for some focus on immunization and family welfare and some relatively inefficient nutritional supplementation is another key factor. Curative care and the increasing privatization and commercialization has resulted in over 65% of health care being in the private sector today, mostly unregulated and unrepresented in the State's 'health monitoring' or health planning systems.
- In addition, health education has been neglected at all levels and rational drug management policies not adequately addressed.
- Inspite of the presence of good **public health resource persons** in the state, public health cadres have neither been nurtured nor strengthened. Also at different levels of health care, decision makers with no skill or capacity in public health policy making have been allowed to make decisions that have therefore supported individualized curative care or the market economy of medicine, rather than sound public health.

Agenda for Action

a. *There is urgent need for strengthening public health competence and skill at all levels of the system to improve **health for all** without distinction or discrimination. This must include a two pronged approach.*

- *All decision makers at all levels beginning from the medical officer of a primary health centre to the leadership both technocratic and bureaucratic at the state directorate level, need to be given **short public health orientation and skill development** as a ongoing continuing education process for capacity development.*
- *Public health competence through relevant training for Diploma, MD, Masters and Doctoral programmes should be built up and a **cadre of public health consultants / specialists** should*

be built up who will take over health planning decisions making in the state over a period of time. These must have the competence to make a broad social – economic - cultural – political situation analysis of the health and health care situation, and be skilled in the challenges both technological and managerial, to address the problem through good team work and empowered community participation.

b. *As a complementary action, the agenda will focus on:*

- ***determinants of health;***
- ***comprehensive health information system and surveillance; and***
- ***preventive, promotive and rehabilitative aspects of every priority problem must become the sheet anchor for health planning and service development in the state.***

This will again mean a proactive reorientation effort at all levels of health care administration and in all the training programmes geared to producing health human power for the health care system.

3. Distortions in Primary Health Care

Though the state has promoted primary health care, this has not been well defined at policy level and has been, additionally distorted by various factors which include:

- **Inadequate** efforts to involve the people in the health planning and management process so that **community participation** if at all has been very passive and adhoc.
- Increased **verticalisation** and **selectivisation** of programmes at the cost of more integrated and comprehensive approaches and at the cost of greater flexibility and local planning effort. Externally aided projects have contributed particularly to this verticalisation and selectivisation.
- Inadequate preparation to empower the evolving **Panchayatraj system** to participate and be actively involved in health decision making at community level.
- Lack of adequate involvement of **general practitioners; local healers and healing systems; voluntary agencies; NGO's and civic society and the private sector** in complementing and supplementing the governments primary health care system.
- Lack of development of **appropriate technology** and very slow up-gradation of the technological competence of the health care system at the primary care level.
- Increased **compartmentalisation** of health care from **intersectoral action** that is so crucial to address the deeper determinants of health, and lack of integral linkages with nutrition programmes including the ICDS scheme; the school system; the cooperative movement; poverty alleviation and development programmes; water supply and sanitation programmes; and women's credit cooperatives.

Not surprisingly the comprehensive concept of primary health care including focus on equity; appropriate technology; intersectoral action; and community participation has been diluted or nearly forgotten.

Agenda for Action

a. *There is urgent need to reiterate the commitment to primary health care as a core principle of health care service development in the state at all levels and sectors within the directorate and the ministry and its associated institutions.*

b. *There is need to improve orientation and capacity for the promotion of primary health care by improving quality of primary health services by strengthening human power resources, maintenance, logistics and supplies and supportive referral systems.*

c. *Simultaneously the strengthening of the community partnership in the ownership and management of the programme should be undertaken orienting and involving Panchayatraj institutions actively in the process.*

d. *A complementary strategy to involve and enhance the participation of local community organisations, voluntary agencies and NGO's; local practitioners of all systems of health care including folk healing traditions, must be actively promoted.*

e. *Finally the crucial intersectoral linkages required to address the determinants of health - income, gender, literacy, housing, water supply and sanitation and environmental pollution and make the primary health care system more integrated and comprehensive, must be urgently promoted*

Making primary health care work must be a renewed commitment.

4. Lack of Focus on Equity

There is growing evidence that inequalities in health between regions and districts of Karnataka and between groups within our society / community are *widening* and despite some efforts the present health care system and *programmes do not address these inequities adequately.*

The inequities identified are

- The northern districts of Karnataka especially the seven districts (category C) have the lowest figures for most health, development and social indicators. Certain talukas in some of the southern districts also show poor development indicators.
- Rural - urban differentials continue to exist and are also widening.
- Gender discrimination is seen in the continuing neglect of the girl child, the increase in female foeticide (sex linked selective abortion); continuing disparity between male and female malnutrition; violence against women; and lower access to care.
- The gaps between the scheduled caste and tribes (SC / ST) sections of the population, and the rest including other backward castes (OBC's) continue to exist, in spite of programmes trying to address this caste / ethnic inequity.
- Other neglected groups in our society include growing numbers of the elderly; continuing numbers of working children including increasing numbers of street children; people with disabilities and a large group of people socio-economically or socially marginalised through a variety of factors in our society.

Inadequate responses to tackle these continuing or growing inequities is an important concern. The lack of focus on equity and disparities is further complicated by inadequate monitoring of these inequities and the continuing lack of disaggregated data to help understand the situation and mount more focussed responses.

Agenda for Action

a. *There is urgent need to address the equity issue by establishing a health monitoring system that focusses on regional disparities, gender inequalities; class and caste / ethnic inequalities; the geographical (rural / urban) divide and collects disaggregated data.*

b. *Equity as a policy imperative must be built into the situation analysis; the goals of the health policy and health care system, and the monitoring of inputs and outcomes. When equity becomes a crucial indicator of health care process then suitable responses will emerge in the health planning and implementation process. Special packages for the seven category C districts; scheduled castes and tribes; women; and other vulnerable groups are required, besides an overall focus on improving rural health care. The best administrative and management expertise must be utilised to work on these areas.*

5. Implementation Gap

Over the last few decades the state has invested in public health, primary health care as well as secondary and tertiary health care. In the last two decades external aid has also been substantially increased to meet new challenges and widen the focus and outreach of existing programmes. A lot of efforts have been put into planning programmes and strategies, and implementation guidelines and manuals of every sort have been evolved. However at all levels and sectors of public health and primary health care, one sees a widening gap between policy intent and implementation; between what is professed and what is practiced. This **implementation gap** is a major area of concern and a major obstacle to improving the health status of our people.

The 'gap' is contributed to by multidimensional factors

- There is **lack of political will** in that health is not high on the agenda of governance. Health budgets are stagnant and often underutilised. The commitment and capacity to get plans off the ground and reach those who need to be reached is lacking.
- There is **overall lack of vision and mission,** and perspectives of health are neither comprehensive nor integrated, with increasing programmatic compartmentalisation that 'misses the forests for the trees'.
- The **planning, administration, supervision** and evaluation of the health system are **poor**, often adhoc and not always evidence based or quality conscious. This is true particularly at programme, district and subdistrict levels. The work of good people get neutralised with resulting frustration and demoralisation.
- **Leadership** of the department has lacked a problem solving orientation, team building and team motivating capacities. Lobbies and interest groups work to further their own narrow, short term interests, at the cost of the greater common good.
- **Individual agendas** based on caste or local politics have often predominated over collective good.
- The continuation of **key and critical vacancies** not being promptly filled up has also greatly contributed to a vacuum affecting implementation. In addition, frequent transfers affecting continuity and lack of younger people at district level also affects the implementation process.
- Surprisingly even in departments and programmes when many of the above factors are not at play there is a **phenomenal apathy** further affected by bureaucratic red tape and delays, or the burden of **not taking responsibility** that has contributed to this growing mismatch between plan and implementation.

Agenda for Action

a. *There is urgent need for a comprehensively articulated State Health Policy which provides the vision / mission / goals and framework for an integrated health plan that has long term perspectives built into the system.*

b. *There is urgent need to raise the status of health on the political agenda and to ensure that adequate financial and budgetary resources are provided to reach health for all goals, in keeping with constitutional and health policy obligations.*

c. *There is urgent need to monitor and improve the quality of health services by increasing competence of health staff; improving logistic support and ensuring supplies; preventing duplication and compartmentalisation; strengthening monitoring of quality care and setting realistic and achievable quality of care standards.*

d. *There is urgent need to increase accountability and transparency to prevent distortions due to extraneous influences of the market economy; of lobbies; social and political agendas; and money power.*

e. *There is urgent need to nurture competent, committed and capable leadership at all levels to maintain, motivation, morale and ethical commitment of health personnel at all levels.*

f. *There is an urgent need to introduce a supportive and problem solving, decentralised, supervisory system so that implementation gaps are constantly monitored and their causes addressed proactively and effectively.*

6. The Ethical Imperative

Over the years there has been a gradual decline in the commitments to ethical values at the professional level which has allowed the market forces and economic gain to distort professional values and commitments. In addition there are an increasing number of social developments and new technologies that have now been included under various legal acts / provisions to ensure that they benefit human development and not cause harm by misuse, abuse, overuse or exploitation. The increasing connivance of the medical profession in sex-selective abortion by misuse of prenatal diagnosis; and the unethical practices, recently exposed in getting donors for organ transplantations are significant examples of these trends.

Ethics and law which are complementary are crucial for the evolution of a comprehensive health policy and health care system - the former providing the spirit and inspiration, the latter the safeguard and framework. If both these are ignored the health care structure will weaken and the framework will no longer respond to the needs and aspirations of the people. The loss of the ethical imperative and the disregarding of legal framework and law determined responsibilities is another contemporary phenomenon which needs an immediate response.

Agenda for Action

a. *The state must evolve a* ***charter of citizens rights and rights of patients*** *and participants of health programmes. These should be distributed widely and people made aware of them through formal and informal programmes. Provisions under the Right to Information Bill should be published and utilised.*

b. ***Ethics and law*** *as they relate to medicine and health must be taught as an integral part of* ***training*** *of all health care professionals at all levels.*

c. *All health professionals must be made fully aware of all the legal provisions that relate to the health care system and be conversant with the legal framework, guidelines and implications.*

d. *Finally some form of monitoring of ethical and legal issues must be professionally determined and organised and government should support all such endeavours in this regard. Citizens groups must be part of this.*

7. Human Resources Development Neglected

There has been an overall neglect of planning and policy for human resource development and deployment inspite of the training of an army of health functionaries of all types and at all levels, through a wide network of institutions including governmental, non-governmental and private institutions.

This neglect is symbolised by

- A lack of clarity of the capacities and skills required by each member of the team;
- An inadequate estimate of the numbers required to be deployed to enhance the efficiency and effectiveness of the system;
- The absence of any clarity in policies of nurture, career development or career advancement; inability to maintain morale and motivation of the health teams;
- Little or no efforts at continuing education excepting some adhoc and sporadic efforts for the doctors;
- Lack of clarity in promotion policies; and
- The absence of social accountability,

In recent years the commercialisation and the unplanned and unregulated growth of health human power training institutions - medical, dental, nursing, pharmacy, other systems of medicine etc - has led to fall in standards, poor quality of training, and infiltration of market values into these mushrooming network of institutions.

Agenda for Action

a. *There is need to urgently develop a state policy on health human power development that is an integrated part of a comprehensive health policy.*

b. *There should be well planned estimates of quantum or number of personnel required currently for every category along with predictions for the next 5-10 years and the norms for recruitment and deployment including promotion.*

c. *There should be sound programmes for nurture, career development, skill / capacity training and continuing education for all categories at all levels. Plans for retraining may also be required.*

d. *The trend towards commercialisation and unregulated mushrooming and growth must be countered by an imaginative HHRD policy which stresses quality over quantity; is competence based; accountable and transparent and which develops in response to the needs and aspirations of the people, and not the changing demands of market forces – local, national or international.*

8. Cultural Gap and Medical Pluralism

As identified in the National Health Policy of 1982 there is a major cultural gap between the aspirations and needs of the people and the culture, personal aspirations, attitudes and work ethic of the health care system and health professionals who work in it. This is symbolised by:

- Continuing lack of awareness or sensitivity of the health teams to:
  - local health traditions and health centre;
  - herbal and folk medicine; and
  - the work of the local health practitioners and traditional birth attendants.

This is further complicated by the dominance of one system over others in our training programmes. This cultural alienation between the health system and the people becomes an obstacle to work.

- Lack of a positive attitude towards medical pluralism that affords to all systems and traditions both respect and an open-minded evidence based scientific approach, promoting dialogue, debate, sharing of ideas and resources.
- Lack of fruitful dialogue between the organised systems of medicine, inspite of state support to educational institutions and research of other systems.
- Lack of a cogent, congruent state policy that considers this rich diversity as an important resource for health planning and is keen to evolve a framework for integration.

Agenda for Action

a. *There is urgent need to strengthen the functioning and development of Indian Systems of Medicine and Homeopathy and to build up better, working linkages, with potential for dialogue between the systems moving gradually towards a more integrated and comprehensive health policy utilising the potential of all these systems at different levels of health care, particularly primary health care and public health.*

b. *At the community level there is urgent need to bridge this cultural gap by making health teams more sensitive to people's needs, life situations, belief systems and aspirations and building primary health care systems and the new public health systems with the full and enthusiastic involvement of the members of the community as empowered participants not passive beneficiaries. This paradigm shift in the dialogue between professional medical culture and peoples health culture is urgently required.*

9. From Exclusivism to Partnership

The health planning and monitoring efforts of the directorate focused only on government health care. This view is too limited and is particularly a matter of concern when it is common knowledge, people's experience, and now researched evidence; that apart from the government there are a large number of other groups who contribute significantly to primary health care and also substantially to secondary and tertiary health care as well. This includes local community organisations and schools; village cooperatives and women, youth and farmers clubs; voluntary agencies and NGO's; the private sector including both general practitioners and the corporate sector; and the large 'mission' sector in health care as well. This isolationist and compartmentalised attitude which ignores the contribution of all other groups / sectors must change radically if the substantial gaps in health needs and health responses have to be bridged.

Agenda for Action

a. *There is urgent need for a comprehensive partnership policy that must enable the health secretariat and health directorate to continue to play the key leadership role in health care along with proactively designing and operationalising functional partnerships with all these sectors and groups.*

- *These partnerships should be well planned, well regulated, well supported and committed to predetermined primary health care and public health goals.*
- *The policy should ensure accountability and transparency of the partners and their supportive supervision, public health orientation and commitment to quality.*

- *Like the government programmes these new partnerships should also move towards community empowerment and increase the ownership and participation of the community.*

10. Ignoring the Political Economy of Health

Over the last decade neo-liberal economic policies have been promoted at both international and national levels. New international trade related agreements like WTO, TRIPS and others are affecting the economies and development strategies of many developing countries. Structural adjustment programmes and conditionalities linked to international development assistance are geared towards reducing social sector spending, removal of subsidies, greater privatisation and contracting out of services. Within the country, new economic policies that favour globalisation, liberalisation and privatisation are also affecting the marginalised sections of society inequitously with widening disparities between classes, between districts and within regions. All these new economic trends adversely affect various aspects of health care delivery systems, with reduction or stagnation of public sector and public health budgets; rise in prices of drugs and diagnostics; contraction of the public sector; the potential impact of WTO and change in patent laws on pharmaceuticals and health care options; increasing corruption and scams; and the impact of all these factors on public health and access by poor to health services and medical care.

An important concern is that there seemed to be no group at the state level which was monitoring or studying the political, economic, social, institutional dimensions of these new trends and their impact on health. This is an urgent imperative.

Agenda for Action

a. *There is urgent need for a multidisciplinary, intersectoral resource group to study the impact of all these new economic trends on the health of the poor and the public health and primary health care goals of the state. This group should not only monitor these trends but also suggest counter strategies and policy responses as well.*

11. Research

Finally one of our greatest concerns was that 'research' of any type – basic or applied; biomedical or socio-epidemiological; field research or action research and operational research was totally neglected in the health sector. In spite of large numbers of ongoing programmes including over ten externally aided projects the focus, the commitment, the outlay, or the importance given to research was surprisingly poor. Research seems to have become a very neglected, under funded activity reflected in the overall poor quality, efficiency or effectivity of health care programmes and initiatives. A radical and renewed commitment is urgently required, since it is through 'research' and objective enquiry that the strengths and weaknesses of our existing system can be identified, and only through research can evidence based solutions emerge.

Agenda for Action

a. *There is urgent need for a **multidisciplinary research** programme to be initiated so that the study, monitoring, evaluation and problem solving approaches to health care development can be greatly strengthened. This programme should be very **strong on behavioural and the social sciences** and not just be biomedically oriented.*

b. *Research by the Rajiv Gandhi University, the medical and other professional colleges; the department of social work, sociology, psychology of the university and NGO's and health policy*

resource groups and consumer groups and civic society should be encouraged, and supported. Greater linkages between the health care system and these research projects would help to generate more ***evidence-based support*** *to change and improve health services.*

12. Countering the Growing Apathy in the System

While all the above factors seem more tangible with definitive agendas for action, the greatest area of concern is a growing apathy and cynicism in the health care system. Many enthusiastic members of the health team at different levels have become more passive and even cynical, due to unfortunate experiences of corruption, political interference, lack of accountability and transparency; routinisation of effort and loss of meaning and a growing cynicism in the larger society. This seems to have reached very substantial proportions. The task force process because of its interactive discussions and its wide range of dialogue has helped to address this apathy and cynicism (which had developed over years) and may have created a short term breakthrough, by providing a large number of people in the system with

- a stake in a change of the system;
- a hope in a more concerted effort to tackle problems;
- a vision for a more people responsive health care.

However unless this inspirational process is maintained and the process of dialogue and involvement enhanced and sustained, all the cross cutting concerns may never get adequately addressed.

Agenda for Action

a. *Therefore the most important agenda for action is the nurture and sustained support to the top health sector leadership. Vision, capacity and enthusiasm must over ride the seniority factor or the caste politics linkages.*

b. *There is need to nurture visionary leadership at other levels that can improve the morale and motivation of the health teams and move them from cynicism and apathy, to enthusiastic team work, so as to reach primary health care and public health goals and to meet the aspirations of the people.*

This is both a challenge and an urgent imperative.

5.11 Poverty and health

Poverty has been defined by UNDP as " the denial of opportunities and choices basic to human development". Poverty has economic, social and political dimensions. It produces helplessness, insecurity and powerlessness. Poverty breeds ill health and ill health leads to poverty. Any attempt at alleviation or eradication of poverty will have its impact on health. So also, improving the health of the people is one sure way of reducing poverty.

5.12 Development and Health

Many developmental activities directly or indirectly affect health. An example would be digging canals to provide for irrigation. The water may partly be used for drinking purposes and thus improve health. But it may also breed vectors (like mosquitoes) and lead to vector – borne diseases (like malaria). Health Sector must develop the capacity to undertake studies and collect data to measure and estimate the possible health impacts of developmental activities. The death and disease burden of development activities should be measured with an estimation of the contribution that the social and environmental factors are making to the health problems, as also the health opportunities presented by developmental programmes.

" Human beings are at the centre of concerns for sustaiinable development. They are entitled to a healthy and productive life in harmony with nature"

- U. N. Agenda 21. Programme of Action for Sustainable Development, Rio declaration on Environment and Development, Rio de Janeiro Brazil, 1992.

6. Critical pre-requisites for intersectoral action for health

Few or no mechanisms are available to enable health professionals and health policy makers to have any significant role in the process of developmental policy making, which needs intersectoral collaboration. Among the critical pre-requisites are:

- conviction among health professional that a key strategy for improving health is to work together with other sectors;
- governments, State and local, should make health central to the development policies;
- a general recognition by all that better health is an integral part of community development; and
- developing the technical capacity to advise other sectors about modifications to their activities that would improve health of the people and actively listening to suggestions of other sectors and acting upon them.

Recommendations

- *The State must establish administrative machinery and Co-ordination committees at the State, district and local levels for intersectoral action for health. These groups must be involved in the preparation of the State plan.*
- *Have a High Power Core Committee (intersectoral) headed by the Chief Secretary at the state level and committees at the district level with participation by D.Cs and C.E.Os. The Committees should have representations from Health, Education Women and Social Welfare, Agriculture, Horticulture, Animal Husbandry. Irrigation, Housing , Industry, Pollution Board and Environment. Subcommittees can be formed to reflect and take action on specific matters.*
- *All developmental programmes must have inputs from the health sector to make use of the opportunity to improve health and prevent problems.*
- *Health personnel (Public Health) should be trained to anticipate and find solutions to possible health hazards of developmental programmes. They should continue their association during implementation, monitoring and evaluation of the programme.*

22. THE KARNATAKA STATE INTEGRATED HEALTH POLICY 2001

(Draft)

CONTENTS

1. Introduction

1.1 Health gains

During the past century and particularly after Independence in 1947, several gains have been made in health and health care in Karnataka. Life expectancy at birth (LEB) has increased from 26 years in 1947 to 66.3 years for women and 65.1 years for men in 1998. The Infant Mortality Rate (IMR) declined from 120 in 1951-60, to 81 in 1981, and further to 58/1000 live births in the late 1990s (SRS, 1998). Smallpox has been eradicated. The state has become free of plague and more recently of guinea worm infection. The incidence of polio has been reduced to just 6 cases in 2000. A widespread infrastructure of health and medical institutions has been developed through government policy measures. A large pool of trained health personnel has also been created through support to training institutions in the public and private sector.

1.2 Health gaps

However, gaps remain. Large rural-urban differences remain, exemplified by IMR estimates of 70 for rural areas and 25 for urban areas (SRS, 1998). Despite overall improvements in health indicators, inter district and regional disparities continue. The five districts of Gulbarga Division (Bidar, Koppal, Gulbarga, Raichur, Bellary) and Bijapur & Bagalkot districts of Belgaum division continue to lag behind. Under nutrition in under five children and anaemia in women continue to remain unacceptably high. Women's health, mental health and disability care are still relatively neglected. Certain preventable health problems remain more prevalent in geographical regions or among particular population groups. Decision making and financial powers are insufficiently decentralized or exercised, to develop swift and effective local responses to health problems.

The public lack confidence in public sector health services, particularly at primary health centres. Lack of credibility of services, adversely affects the functioning of all programmes. Underlying reasons for implementation gaps need to be understood and addressed.

1.3 Health policy approach

The State has so far followed policy guidelines through the framework of successive Five Year Plans developed by the Planning Commission, decisions of the Central Council of Health and Family Welfare, central health legislation and national health programmes developed by the Central Government. Over time, separate policies at national level have developed for health (1983), education for health sciences (1989), nutrition (1993), drug policy (1988 and 1994), Medical Council of India (MCI) guidelines (1997), blood banking (1997), the elderly (1998), and population (2000). All these have served the State well in developing its health system, and will continue to be used as a standard for further growth.

Health however is constitutionally a state subject. Health needs, defined socio-epidemiologically, vary between states and even districts, requiring more specific planning. Health expenditure is met largely by the State budget, with 82% of public sector expenditure on health from the State Government of Karnataka and 18% from Central Government. A comprehensive Karnataka state policy for the integrated development and functioning of the health sector is therefore being articulated explicitly, for the first time in 2000-2001, at the turn of the millennium. The policy with a strong emphasis on process and implementation will be an instrument for optimal, people oriented, development of health services.

- It will build on the existing institutional capacities of the public, voluntary and private health sectors.
- It will pay particular attention to filling up gaps and will move towards greater equity in health and health care, within a reasonable time frame.
- It will use a public health approach focussing on determinants of health such as food and nutrition, safe water, sanitation, housing and education.
- It will expand beyond an excessive focus on curative care and further strengthen the primary health care strategy.
- It will encourage the development of Indian and other systems of medicines and healing.
- It views health as the right of every citizen and will work within a framework of social justice and decentralization as envisaged in the 73rd and 74th Constitutional Amendments.
- Most importantly it is intended to be a guiding document that needs to evolve and be changed in response to changing situations.

This policy evolution derives from intense, interactive discussions organized at all levels through the Karnataka Task Force for Health, throughout 2000 and early 2001.

2. The Karnataka vision statement for better health and health care

2.1. Karnataka State recognizes the immeasurable value of enhancing the health and well being of its people. The State's developmental efforts in the social, economic, cultural and political spheres have, as their overarching goals, improved well being and standards of living, better health, reduced suffering and ill health, and increased productivity of its citizens. It is recognized that health and education are central to development. Health is a basic human right, an entitlement, and an individual and collective responsibility. The constitutional mandate, role and responsibility of the state (government) in giving direction, in creating a policy framework, in health care provision and related endeavours including maintenance of standards of health care, is of critical importance in meeting these social development objectives.

The understanding of health was articulated by the World Health Organisation (WHO), 1948 as *"a state of complete physical, mental and social* well-being and not merely the absence of disease or infirmity"* creating the ability to lead a *"socially and economically productive life"* (WHO 1978). This is the ideal towards which individuals and institutions in society strive. While India and Karnataka accepted the goal of the World Health Assembly of 1978, of Health for All by 2000, it is acknowledged that this has not been achieved. The State will work with a sense of greater urgency and commitment to a renewed goal of Better Health for All, Now, particularly for the underprivileged.

Karnataka reaffirms the relevance of the strategy of Primary Health Care, and the importance of practising the principles of Public Health in order to reach this goal.

The state is supported in its health and health related efforts by the Constitution of India, which states in its Directive Principles that,

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic or social condition."

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* *Addition of the word 'spiritual' was suggested by India, but was not accepted by others, who argued that it was included in social.*

The 1983 National Health Policy recollected the aim of the Constitution of India for *"the elimination of poverty, ignorance and ill health"*, and its direction to the State, *"to regard the raising of the level of nutrition, the standard of living of its people and the improvement of public health as among its primary duties, securing the health and strength of workers, men and women, especially ensuring that children are given opportunities and facilities to develop in a healthy manner"*.

The United Nations Universal Declaration of Human Rights, 1948, of which India is a signatory, states that *"Everyone has the right to a standard of living adequate for the health and well-being of himself (herself) and his (her) family"* (words in brackets have been introduced).

2.2. The State and her people are proud of the several achievements made in terms of improved health and better access to health care. However, the State also a recognizes that some goals have not been met. The State expresses certain current concerns and commitments.

- It is concerned about the current inequalities and inequities in health status by region, urban / rural location, gender, social and economic groupings.
- It is also concerned that good quality health care services are unevenly distributed and are inaccessible and unaffordable to a significant proportion of its citizens.
- It is aware of the escalating prices of diagnostics, medical therapeutic technologies and pharmaceutical products that are occurring as a result of globalization.
- It also recognizes the health impact and consequences of broader policies that affect employment, income, purchasing capacity, food security, education and pollution.
- The State accepts that public sector expenditure for health, while growing, does not meet recommended norms and is inadequate to support health services to respond to basic health needs. Out of pocket expenditure by people, largely in the private sector, while fairly substantial, has not produced requisite health gains and also results in adverse economic consequences to families, especially the poor. Judicious investment in health brings major gains in terms of human well being, development and economic productivity.
- It acknowledges the growing recognition, that access to comprehensive health care has a poverty alleviating effect.
- It also recognizes the urgent need to address poverty and inequality, and the social forces that underpin them, as poverty and ill-health linkages are strong, having been adequately researched and documented.
- It is committed to pursuing social development policies and increasing intersectoral coordination to accelerate improvement of health of all sectors of society in an equitable manner.
- It recognizes the critical role of the state to initiate and steer policies;
  - to ensure equity and quality of care;
  - to promote the sustainable development of public health services;
  - to promote community/ peoples' participation in the governance of health service;
  - to facilitate private and voluntary health sector growth as augmenting health care while maintaining professional and ethical standards and keeping in mind distributive justice;
  - to provide adequate resources to different levels of health care and to maintain accountability and transparency in functioning.

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  - to facilitate private and voluntary health sector growth as augmenting health care while maintaining professional and ethical standards and keeping in mind distributive justice;
  - to provide adequate resources to different levels of health care and to maintain accountability and transparency in functioning.

3. Karnataka – Mission Statement on Health and Health Care

3.1 Karnataka State, through a process of planned policies and strategies, and through ongoing reflection, research and learning, aims to respond to the aspirations of its people for better health and for improved access to good quality health care. It will do this by using policy mechanisms and instruments to create and support an enabling environment for further development of the entire health sector – public, private and voluntary. It will foster active participation of people through decentralized systems to take part in the governance and social control of the medical and health sector.

3.2 Karnataka state has rich spiritual, philosophical and cultural traditions. In keeping with these, the development and functioning of the health sector will be guided by values of equity, ethics, accountability, concern and respect for all people, participatory democratic functioning and respect for local health knowledge and culture. Principles of integration, decentralized governance, working in partnership, social inclusiveness, community participation, empowerment and gender sensitivity will be actively promoted through all its health sector interventions.

3.3 The Karnataka State Government will foster the further development of living and working conditions that improve the health status of all its people, particularly of the poor and marginalised. It will work, in the next five years, towards ensuring that all citizens have access to the basic determinants of health. These include nutrition, housing, employment, safe water, sanitation and education, recognizing that many of these lie outside the health sector. It will provide an enabling environment for the equitable growth and development of good quality health care services in the public, private and voluntary sectors, based on humane moral and ethical values. It will actively encourage a spirit of collaboration and cooperation between the different sectors and also with elected bodies and citizens' initiatives. It will put into practice the principles of public health and the primary health care approach, including the education of health personnel. It will govern and nurture the vast number of personnel working in its network of health services in the Directorate of Health and Family Welfare, in urban municipal and other bodies.

4. Karnataka health policy perspective and goals

4.1 Building on strengths of the system evolved over the years, specific will be undertaken at various levels and within a reasonable time frame, to further improve health status and increase people's access to health care, particularly for women, children, disadvantaged communities and regions, the disabled and the elderly in Karnataka.

4.2 A comprehensive integrated approach will be used to develop the health care sector, so that it is responsive to the health needs of the community, defined socio-epidemiologically.

4.3 There will be a strengthening of public health systems, using the primary health care approach, with an emphasis on community participation and inter sectoral coordination. Functioning referral systems will be built with secondary and tertiary health care services. Health management and hospital administration will be further developed. Building institutional capacity, including leadership, professional competence, communication skills, managerial skills and teamwork will be encouraged and fostered at all levels.

4.4 While efforts will be made to increase financial and human resources to the health sector, from public and private sources, issues of sustainability, cost-effectiveness, self-reliance, accountability and transparency will receive serious consideration.

4.5 Human resource development will be ongoing, through appropriately designed basic and continuing education and accreditation systems, which will be introduced in a phased manner for all grades of health and allied professionals. Social and community orientation will be a major focus.

4.6 Partnerships will be built with institutions and practitioners from the private and voluntary health sectors, also ensuring maintenance of acceptable professional and ethical standards.

4.7 Health promotion and empowerment will be a thrust area with active involvement of the education sector, media and civic society.

4.8 Indian systems of medicine, homeopathy, local health traditions, Tibetan medicine and other systems of healing will receive greater recognition, resources and support, to contribute to overall health goals.

4.9 Decentralized planning and functioning within the health system, and decentralized governance through the Panchayat Raj system will be developed further with professionalism, accountability and fairness.

4.10 Values of equity, gender sensitivity, accountability, transparency, fairness, self-reliance, humaneness, respect for local health knowledge and culture and participatory democratic functioning will form the guiding principles, with explicit efforts made towards internalizing them.

Indicators and systems for monitoring and evaluation will review and assess progress towards achieving specific objectives that derive from the goals.

5. Karnataka Health Policy Components

5.1 Scope of policy – comprehensiveness and integration

To facilitate the balanced development of health systems and services, responsive to health needs and aspirations of people, Karnataka State considers it necessary to have a comprehensive health policy statement in which different elements are integrated together and viewed as a whole. Various units and sub-sectors may evolve more detailed policy guidelines. However, this comprehensive statement will allow each one to be placed in the context of others. A comprehensive approach is important, since at the point of delivery of services or the point of contact between the public, the patient and the provider, there is need for horizontal integration.

The need for development of comprehensive health care was first identified by the Bhore Committee in 1946. The importance of integrated health services was reiterated by the National TB Programme in 1962. The damage caused by vertical programmes was recognized by the Kartar Singh Committee in 1973. It recommended integration, as did the Srivastava Committee Report in 1975. The State will undertake measures to operationalise a comprehensive, integrated health service, with promotive, preventive, curative and rehabilitative health care services at primary, secondary and tertiary levels, linked together with good referral systems.

5.2 Public health approach and primary health care strategies

The practice of public health principles was strong in the State till the sixties. These unfortunately declined since the seventies. The state recognizes the value of practicing public health and primary health care, for the common good of all citizens. It has committed itself to revitalizing these aspects. While the clinical or curative approach to health is focused on individual persons and their disease problems, public health tries to protect, promote, restore and improve the health of all people, through collective action.

Programmes, services and institutions give priority attention to disease prevention and health promotion, responding to the health needs of the population as a whole, particularly the deprived. Public health addresses the basic determinants of health. Epidemiology is one of the basic sciences of public health, studying the distribution and determinants or risk factors of disease and ill health in society. Public health interventions address communicable disease transmission and attempt to reduce risk factors for other diseases. An evidence based approach using action research and other sources will help develop and fine tune strategies. This will be supplemented by feedback from the public, from patients and from frontline implementers or health personnel. This will enable the development of a problem solving approach that is locally specific.

Public health and primary health care work in synergy, particularly emphasizing principles of,

- intersectoral coordination at all levels, especially at the district and below;
- community participation through panchayati raj institutions and other mechanisms and fora for involvement in decisions making concerning their own health care;
- equitable distribution of good quality care; and,
- use of appropriate technology for health.

The primary health care strategy does not focus only on the primary level of care but also on the secondary and tertiary levels.

The new public health recognizes and attempts to address the socio-cultural and political economy factors that affect health status and implementation of health programmes.

5.3 *Equity in health and health care*

Equity will be a key policy thrust, encompassing four main parameters, namely, region, disadvantaged groups (Scheduled Castes and Tribes), gender and vulnerable groups (street children, elderly).

a) Region

The state is deeply concerned by recent data analyses that reveal continuing regional disparities in health status, in distribution of primary health care facilities and in their utilization. The districts of Bidar, Gulbarga, Raichur, Koppal, Bellary, Bijapur and Bagalkot scored the lowest on all indicators. These districts will receive priority attention through a special package of services inclusive of infrastructure development, additional personnel, a good management structure and special efforts at community empowerment for health, particularly with women, through women sanghas and NGOs.

5.4

The districts of Belgaum, Gadag and Chamarajnagar have negative indices at a lower level, while Dharwad and Bangalore Urban lack government primary health care services. These districts also require attention.

The districts of Kodagu, Uttar Kannada, Chikmagalur, Udupi, Dakshin Kannada, Shimoga and Bangalore Rural have better indices regarding health determinants, health status and utilization of health facilities. However, specific pockets and population groups within them are more disadvantaged and vulnerable. Services here will be maintained with a focus on vulnerable groups and taluks or areas.

5.5

Taluk level disparities have also been identified in all divisions of the State. These will be factored into the planning process.

b) Disadvantaged groups

Persons from Scheduled Castes and Scheduled Tribes will receive priority attention. Besides primary care, access to complete treatment, follow up and referrals, to secondary and tertiary care services at very subsidised costs, will be assured. The camp approach will be replaced by ensuring good quality care for vulnerable groups within the health care system. For indigenous people a package with nutrition communicable disease control, care for specific diseases such as sickle cell anaemia and special norms for health services will be implemented.

c) Gender

The poor status of women's health, the declining gender ratio and poor coverage and quality of mother and child health services are areas of concern. Measures to improve women's health status and access to care will be implemented and closely monitored. Efforts will be made to increase the number of women doctors, senior health assistants (LHVs and ANMs) by providing adequate residential facilities and personal security. This will be done, particularly at Primary Health Centres and Community Health Centres. The districts with poor health indicators currently, namely Bidar, Koppal, Gulbarga, Raichur, Bellary, Bijapur and Bagalkot will receive high priority. Quality of maternal health services will improve, in particular emergency obstetric care. Widely prevalent conditions affecting women, such as anaemia, low backache, cancer of the cervix, uterine prolapse and osteoporosis will be addressed. Services for psychosocial problems and emotional distress will be developed. Empowerment of women for health will be encouraged and supported. Programmes for the special needs of adolescent girls and boys will be developed in collaboration with the department of education.

d) Vulnerable groups

Innovative, flexible and collaborative approaches for meeting the health needs of street children, out of school and working children, persons with disability and the elderly, will be used.

5.4 Quality of care

Having developed an extensive statewide health care infrastructure over the past five decades, an important policy thrust area in the next phase will be improvement in quality of care and patient satisfaction. Standards of care for different levels of health institutions will be developed. Mechanisms will be established to assure good quality medical and public health care in public institutions and to facilitate and ensure similar standards in the private and voluntary sector. Mechanisms may include accreditation, repeat registration, legal measures, mandatory continuing education for all health care personnel, patients charters and grievance redressal systems. Provisions of good care to patients will be the primary concern.

5.5 Multisectorality and intersectoral coordination

Intersectoral coordination has been inadequate even though its importance was recognized since the late 1970's. Working links, joint programmes and regular communication will be institutionalised between the Directorate of Health and Family Welfare and the Departments of Women and Child Development, Education, Rural Development and Panchayati Raj, and the Public Distribution System in particular. Links with the Water Supply and Sewarage Boards, Pollution Control Boards will be developed with clarity

regarding the roles of each department and areas of shared responsibility. Functional mechanisms at village/ward level, taluk, district and state will be developed.

5.6 *Public, private and voluntary sector partnerships*

Though already existing in an adhoc and often informal manner, public private and voluntary partnerships will be further developed in a planned, systematic manner in order to develop in spirit and practice a collective, community ownership for better health care and also for optimal utilization of health resources. District and Taluk health action networks and issue based networks will be encouraged with active participation from the public sector in such voluntary sector initiatives.

5.7 *Health Financing*

Greater attention will be paid to equitable health financing systems in view of the rising costs of medical care and the large out of pocket payments that often have adverse consequences on the poor. Social insurance schemes, prepayment schemes, selection of cost effective strategies including use of generic drugs and central purchasing will all be tried out.

State government spending on health will be brought up to acceptable norms, as investments in the social sector are recognized to produce gains in human development. The present allocation is not adequate to meet the needs; it is also much less than what has been suggested by various organisations, including the World Health Organisation. The allocation much be increased in a phased manner. Equitable proportions of spending will be in the primary, secondary and tertiary levels and between rural and urban areas. Resource flows will help increase access to quality health care in rural areas. Allocation and spending on health promotion will be enhanced. The indigenous systems of medicine and homeopathy will receive a higher share of resources. 5.9

A system for state health accounts with necessary data bases will be developed to monitor health revenue and expenditure, including those from externally assisted projects and centrally sponsored schemes. District wise health expenditures will be analyzed, reported in annual reports and made available to people on request. A larger proportion of funds will be allocated to the Panchayati Raj Institutions, including some untied funds to enable district authorities to respond to local needs. Districts with a lower ranking on the Human Development Index need more funds for health, but may also a lower capacity to utilize it. Besides increased resource flows, financial management and administrative capacity will also need to be strengthened in these districts. Systems of transparency and accountability will be established.

Pilot studies will be undertaken and encouraged to experiment with innovative health financing schemes such as community financing and social insurance, with particular focus on the rural and urban poor.

Since the Government of India has opened up the health insurance sector to private and foreign investment, the state government will introduce mechanisms to ensure that they operate in an equitable manner seeing that the interests of consumers/ patients, particularly the underprivileged are protected. Regulation of health insurance through appropriate authorities will be undertaken. Public sector insurance companies will be promoted. 5.1(

5.8 *Health Planning*

Health planning will be undertaken at state level more and more, keeping in view national policy and programme guidelines. The state will institutionalize a strategic planning monitoring and review unit, into the Directorate/ Secretariat. The unit will use an evidence base whenever necessary and possible.

Epidemiological units will be developed alongside the surveillance units, at district level and state level. Descriptive and analytical work will be undertaken, by the epidemiological units, in priority diseases and health problems. They will help to improve the quality of data collected through the surveillance systems and HMIS.

The Strategic Planning Cell (SPC) will have a multidisciplinary team including economists, sociologists and anthropologists. Studies will be undertaken by them and also contracted out to other institutions, including educational institutions. The SPC will need to be supported by adequate facilities, such as computers, library and online information systems. Over time, a medical and health research body or council will be established at the State level with links with the State Institute of Health and Family Welfare and the Rajiv Gandhi University of Health Sciences. The council would undertake relevant research to support decision making and planning by the Health Directorate. This will make planning more systematic, rational and responsive to local needs and situations.

Health financing and health personnel planning will be a critical and ongoing part of the state health planning.

5.9 ***Health Management and Administration***

Through a process of recruitment of trained personnel and in service training, skills in health management and administration will be strengthened. Two streams of the health cadre are being envisaged for medical care and public health respectively. The public health stream of the health cadre will have programme management and implementation skills. In the medical care stream, hospital administration, especially for hospitals above 50 beds, will be professionalised.

The Health Management Information System will be an important means for decision making and for introducing correctives at institutional and higher levels.

Issues such as leadership, governance, strengthening institutional capacity, developing efficient communication systems, within and between tiers and levels, will receive priority attention, with the help of experts and institutions such as the Indian Institute of Management.

Sections for engineering, construction and infrastructure maintenance; equipment procurement and maintenance; drug procurement and transport, will be strengthened in-house and developed further into specialized units. These are critical support areas for health systems to function optimally.

The newly introduced systems, under the Karnataka Health Systems Development Project (KHSDP), for contracting out non-clinical services such as cleaning, laundry, security, dietary department etc., will be reviewed and the positive aspects internalized. Minimum wages and working conditions of staff under these systems will be ensured.

5.10 ***Environmental Health***

Environmental health is an important issue of concern with increasing pollution of air, water and soil due to rapid and sometimes unplanned industrialization, inadequate compliance with pollution control regulations, poor monitoring and control systems. Motor vehicle fumes also add to the toxic chemicals in the air. Excessive use of chemical pesticides including those, which are banned, are causing pollution of the food chain. The State will introduce measures to control exposure to these sources of pollution in order to protect its citizens from these health hazards. Environmental and health impact assessment studies will be undertaken around industrial and power plants, dams, mines etc. and clearances will be required before new plants are commissioned.

The health sector will also take responsibility to ensure the improvement of drainage and sullage systems and solid waste management in keeping with the guidelines of the committee set up by the Supreme Court of India.

The government will ensure water quality through a monitoring and surveillance system according to accepted norms and standards.

Health education and health promotion activities will promote personal hygienic practices and methods to safeguard against environmental health hazards.

5.11 ***Nutrition***

The magnitude of undernutrition and deficiencies in Karnataka revealed by recent data, place nutrition as a major public health problem in the state.

The state policy reflects the National Nutrition Policy (NNP) adopted by the Govt. of India in 1993 and the National Plan of Action in Nutrition (NPAN) developed in 1995 by the National Standing Committee on Nutrition.

The ***goals*** to be achieved by 2007 are:

(a) Reduction of under nutrition (Gomez classification) among pre-school children as follows - severe undernutrition to 3% from 6.2% (1996); moderate undernutrition to 30% from 45.4% (1996). (b) Reduction in anemia among women from 42% (1998) to 30%. (c) Reduction in anemia among children from 66% (1998) to 50%. (d) Reduction in new borns with low birth weight from 35% (1994) to 10%. (e) Elimination of blindness due to Vit. A deficiency and elimination of iodine deficiency in goiter prevalent districts. (f) Promotion of balanced, low cost diets using locally available foods for different age groups including children, adolescents, pregnant and lactating mothers and the elderly. (g) Improving household food security through poverty alleviation programme.

The ***short-term interventions envisage*** district wise goals and targets will be developed, nutrition interventions for vulnerable groups, particularly:

(a) Focussing on under-twos with supplementary foods. (b) Expanding the nutrition intervention net (ICDS, UIP, ORT)* with wider coverage, regularity and better quality, with special attention to girls and underprivileged social groups. (c) Empowering mothers and families with nutrition and health education, with emphasis on caring for children and on low cost, locally available nutritious foods. (d) Control of iron deficiency anemia, Vit. A deficiency and iodine deficiency.

To achieve the above, the state will enhance its investment in nutrition interventions, will fill up vacancies and ensure full capacity of staff, strengthen supportive supervision and improve/ develop nutrition monitoring systems.

The indirect, long term institutional and structural changes, as also recommended by the National Nutrition Policy, 1993, are:

(a) improved food security; (b) increased production of nutritionally rich foods such as pulses, oilseeds and ragi, and protective foods such as vegetables, fruits, milk, poultry, fish and meat; (c) improved

* *Integrated Child Development Services (ICDS), Universal Immunization Programme (UIP), Oral Rehydration Therapy (ORT).*

purchasing power by active implementation of poverty alleviation programmes; (d) strengthening the public distribution system; (e) preventing food adulteration; (f) improving the status of women; (g) ensuring community participation.

5.12 Population Stabilization

Population stabilization through fertility decline has long been a goal of the state government, in consonance with national priorities. It is widely recognised that the public sector in particular has generated awareness, demand for services and has also provided widespread access to contraceptive and family welfare services, especially terminal methods, and to health care. There have been resultant gains with declines in birth rates from 41.6 (1951-60) to 22.1 (1998-99), death rates from 22.2 (1951-50) to 7.9 (1998-99), and growth rates from 2.2 (1951) to 1.8 (2000 estimate). The Total Fertility Rate (TFR) is 2.13 and the effective Couple Protection Rate (CPR) is 60%. **Thus the State is fairly near to reaching replacement levels of fertility**. Data indicates declines in growth rates, particularly after 1981 in all districts except Gulbarga division (with slower or stagnant declines). This momentum of decline is likely to continue. Expert analysis suggests that **improvement in social development, quality of life and gender development will hasten the process of demographic transition. This will be an important component of the state strategy, with emphasis on districts in greater need.**

Drawing from the guidelines of the National Population Policy 2000 the State will follow certain **basic principles.**

- It will promote the spirit of voluntarism and will protect human rights. It will not adopt coercive strategies in any form.
- It will provide good quality contraceptive services, integrated with primary health care throughout the state. Reproductive technologies that are safe and effective will be used. Quality of care will be further improved with screening, follow-up services, managing and minimizing side effects. Spacing methods will be made more available and more popularized. Male methods will be increasingly used, reducing the burden from women only.

  The government is committed to providing for informed choices and to seeking the consent of citizens.
- Responding to the specific situation in Karnataka the State will develop a special package for districts with greatest unmet need in terms of health and family welfare services. It will endeavor to increase the utilisation of these services by making them user friendly, being particularly sensitive to the special needs of women.

The objectives of the state in terms of population stabilization are:

- To provide good quality family welfare services integrated with general health care services to all sections of the population, particularly in areas of greater need, though strengthened health care infrastructure and health personnel and by developing partnerships and coordination within and between government departments, with industries, the private sector and voluntary sector.
- To bring the Total Fertility Rate to replacement levels in all districts at the earliest, by 2005.
- To achieve a stable population by 2030.

Strategies and Steps to be taken will include:

- Setting up a State Commission for Population and Social Development.
- Making all efforts to ensure adequate facilities for good quality mother and child health care.
- The State will attempt to develop a good civil registration system, working towards 100% registration of births, deaths and marriages. It will pilot this in a few districts and then expand. This will help provide accurate information regarding population dynamics.
- The State is concerned about increasing son preference that is adversely altering the gender ratio. It will implement legal measures such as The Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act 1994 to prevent female foeticide. It will also strengthen norms about the intrinsic value of girl children.
- Introducing life-skill and population education for adolescent girls and boys, using methods that capture their interest and responding to their needs.
- Promoting delayed marriages for girls in particular and boys, delaying of the first pregnancy and spacing of the second child.
- The equitable and sustainable social development dimensions of a people centered population policy, including the education for all children; enhancing programme, implementation for basic amenities (and rights) such as safe water supply, sanitation and health care; increasing employment; and empowerment of women. Given the broad scope of interventions, implementation of the Population Policy would not be the sole responsibility of the Department of Health and Family Welfare, but will involve considerable intersectoral coordination for which working mechanisms will be established.

5.13 Education for Health Personnel

Learning and education in Indian tradition are accorded an almost sacred place and role. Karnataka has many achievements in the realm of education for health personnel, including medical and all allied health professionals. Institutions of high quality have developed. The private sector has been encouraged and a vast network of educational institutions has been established. The relatively new Rajiv Gandhi University for Health Sciences is working towards ensuring better academic and professional standards and norms.

Institutes and systems for education, training and continuing education play a critical role in the formation of medical and allied professionals, and in the maintenance of this human resource as a well-informed, up to date and motivated force. This is particularly important in a profession on whose decision-making abilities and practices depend the life, health and well being of people. The regulation of the profession including of its educational systems and institutions and the role of the state therefore are issues of great importance.

A situation analysis reveals many ills in the health personnel educational system and institutions and in professional practice and conduct. These include a rapid expansion in quantity, namely numbers of educational institutions and seats, at the expense of quality. There is an overproduction and supply particularly of medical graduates. In post-graduation, there is a mismatch between the specialties, with certain specialties remaining underrepresented. Growing commercialisation and corruption in student selection, during examinations, and in the professional practices of teachers, cause double standards, with dilution of professional standards and ethics. Student and patient interests are compromised with inadequate numbers of teaching staff, inadequate and poor quality infrastructure and equipment. Professional councils are often not playing strong roles to regulate their respective disciplines.

Keeping these and other factors in view, the health policy has evolved certain **principles and strategies for education for health personnel.**

- The focus will not be only on medical education of doctors but on all allied health professionals and on Indian Systems of Medicine and Homeopathy. The functioning of a variety of health professionals in teams makes for better health care services to respond to people's needs. Conducting team training will be encouraged.
- Norms regarding number of institutions and number of seats will be respected. Issuing of essentiality certificates and University affiliation for new medical, dental, nursing, pharmacy and physiotherapy colleges will be stopped for the next 3 years, with an exception for nursing colleges in the under-served areas of Karnataka. The distribution of institutions will receive greater attention. The number of students per college will be stipulated (e.g. maximum of 100 per batch in a medical college) in order to maintain quality.
- Similarly the moratorium on new Ayurvedic, Homeopathic and Unani Colleges will continue for two more years.
- Efforts will be made to improve the infrastructure and functioning of existing colleges (all systems, all levels) bringing them up to acceptable norms laid down by professional councils. The State will in particular initiate measures in this regard for government teaching institutions and hospitals. It will allocate resources for repair, maintenance and where justified extensions of buildings. Similarly systems for regular equipment repairs, and maintenance will be established. Staffing will be according to norms in the teaching and non-teaching category. Essential Services will be maintained round the clock especially emergency services, casualty, accidents, burns, X-ray, laboratory, blood bank etc. Uninterrupted supply of drugs required for such institutions will be made available.
- A study of financial and other resource requirements for these institutions will be made, with various options for raising of resources and for ensuring sustainability of these institutions.
- Closer working links will be encouraged between the University, educational institutions and health services for mutual advantage and development. Health Service professionals can undertake some teaching responsibilities, while a part of the teaching of undergraduates and postgraduates could be based in district and taluk hospitals, with postings to CHC and PHC's as well. Teaching staff also will be exposed to the reality of situations in such institutions so their teaching and research could be relevant. Teaching institutions, will work in collaboration with the Department of Health and Family Welfare in service provision in a specified number of PHC's / CHC's / Wards etc.
- Improvements will be made in the pedagogy of health science institutions. The University and Para –Medical Board will organise Teacher Training Programmes on Teaching Methodology for health sciences suited to adult learners. It will be mandatory for teachers to undertake these courses. Learner centred, problem-solving approaches will be used, moving away from the banking system of education. Each institution will be encouraged to initiate and run educational units with the specific objective to improve teaching capacity. Systematic feedback from students will help to modify training programmes. Performance appraisal of teaching faculty will help to further develop their competence.
- State Councils, such as the Karnataka Medical Council, Dental Council, Nursing Council, Pharmacy Council etc. need to be strengthened and professionalised. They should also to provide for

community representation through consumer groups, NGOs and then professionals being nominated or co-opted in order to reflect social and community concerns. The Councils could develop a good information and knowledge base and also a database regarding their membership.

A Commission at State level will bring together representatives from different councils, including Indian Systems of Medicine and Homeopathy along with government policy makers and University / board representatives to address issues raised by the National Education Policy for Health Sciences. The Commission will need to be alert to trends in the sector including negative trends mentioned earlier and make suggestions for regulations and correctives.

- The State Institute of Health and Family Welfare will be developed into a high quality centre for training and continuing education, especially in the fields of public health, management and ethics, linked with the Rajiv Gandhi University of Health Sciences. It will provide orientation and in-service training to personnel from the department of health. It will be linked with the district and health worker training centres. Its infrastructure will be upgraded especially, library, teaching halls with audiovisual equipment and computer facilities, as also personnel. It could offer certificate and diploma courses. It will be encouraged to develop links with other educational and specialized institutions, including the Indira Gandhi Open University. It will also undertake research studies

5.14 Rational Drug Policy

The government is aware of the advances and developments made by the pharmaceutical industry in the country and in the state, with good technological and production capacity, high turnovers and exports. However it is concerned that essential drugs of good quality are not available in adequate quantities to many, particularly in rural parts of the State. The rising cost of drugs especially in recent years, and adulterated substandard drugs are also areas of concern.

The State has developed a public sector pharmaceutical concern, the Karnataka Antibiotics and Pharmaceuticals Ltd (KAPL), which has been functioning well and at a profit over the years. There are also several small scale producers and larger Indian companies, besides foreign and multinational companies in the state. The public sector, organised Indian private sector and small scale sector are the major producers of bulk drugs, while the others operate in formulations and in production of inessential drugs which are more lucrative.

There are over 60,000 formulations of medicinal drugs in the market. The essential drug list of the World Health Organisation (WHO) has listed about 300 drugs necessary for secondary care, while only about 25 – 30 drugs are required for primary care. However these drugs, are produced much below requirements estimated according to epidemiological need and also below licensed capacities, resulting in shortages. These are drugs required for common diseases such as tuberculosis, worms, filaria, typhoid, anaemia etc. On the other hand there is abundant production of vitamins, tonics, health drinks, cough and cold preparations, over the counter preparations (OTCs), tranquilizers, antacids etc. The production and sale of irrational and hazardous drugs is another area of concern.

The State recognizes its responsibility as to ensure that all people are able to obtain the drugs they need or required at a price that they and the state can afford; that these drugs are safe, effective and of good quality. It will implement this responsibility through various measures, including better drug selection, pooled procurement, quality assurance, management and transparency in procedures, using resources in

a socially productive way, and encouraging participation and discussion from the public and professionals in this vital area concerning lives and health of citizens.

- The Government supports the concept of essentiality based on criteria of therapeutic need, efficacy, safety and value for money. Essential drugs only are selected for the Rate Contract lists. Essential drug lists for different levels of institutions will be adopted.

  Spreading of information concerning essentiality and essential drug lists to medical professionals, pharmacists and to citizens will be promoted in consumer and patient interests. The patients / citizens right to information will be protected by making available information about harmful, hazardous, irrational and essential drugs.

- The government supports the system of monitoring Adverse Drug Reactions (ADR) already initiated by the Karnataka State Pharmacy Council. It will increasingly get all its institutions linked to the system. Early detection of ADRs will allow for corrective actions to be initiated.

- The state through its technical bodies will keep abreast of latest developments regarding drugs and therapeutics and will initiate suitable action to withdraw hazardous drugs from the market in consumer interest e.g. baralgan (a hazardous antispasmodic), novalgin (a hazardous analgesic), enteroquinol (a hazardous antidiarrhoeal). Outside experts, the pharmacy council and consumer activists will be inducted into technical bodies. The names and lists of banned drugs and their formulations and trade names will be widely publicized.

- Drug package labeling and package inserts will be made to carry unbiased drug information and cautions to consumers of warnings for drugs not to be taken during pregnancy, drugs not recommended for the elderly, for children, for people with liver or kidney impairment etc. This should be made available in Kannada also and in print large enough to read. The state recognizes its responsibility in protecting the health of its citizens against iatrogenic problems, since health is of higher value than profits to companies.

  In this it will also endeavor to enhance the knowledge of medical and allied professionals through professional and other bodies. The ethical and legal aspects of the need for rational therapeutics will also be highlighted.

- It will strengthen the Drug Control System by providing for adequate staff with the required qualifications. It will introduce inspection of good manufacturing practices as recommended by WHO. Systems will be established wherein prescribers can send drugs they suspect to be substandard for testing. Random samples of drugs will be sent for testing in recognised laboratories in the state and in different parts of the country.

- Key staff and doctors will be trained in rational drug policy issues and in how to identify and solve problems relating to drug prescription, dispensing and consumption. Newsletters and updates on drug categories, cautions, contradictions, side effects, dosage for different age groups etc., will be made available to improve quality of service to consumers.

- Monitoring and studies of prescription practices, pharmacy practices etc. will be encouraged to provide regular feedback for continuous improvement in the area of rational therapeutics

- Rational drug policies for the Indian Systems of Medicine and Homeopathy will also be introduced following discussions with their Councils and experts.
- Measures to increase effectiveness of drug procurement, warehousing and distribution are also being undertaken.
- Expert groups will look at drug pricing issues and issues relating to access to drug for persons with HIV / AIDS with psychiatric illnesses and other diseases requiring new drugs which fall under the new patent laws and are therefore out of the reach of the majority of people.

  The State will study the impact of the new patent regime on the pricing, production patterns and availability of pharmaceuticals. Necessary measures will be taken to protect the interests of patients and consumers.
- The State will support strategies in collaboration with professional and consumer bodies to ensure safe drugs and rational drug use for people. It will be alert to implementation of drug policies, including bans. Problem drugs or unsafe drugs will not be allowed to be marketed or used e.g. pediatric preparations of loperamide or diphenoxylate, unnecessary combinations of antibiotics with antidiarrhoeals, analgesics, irrational over use of second line antimalarials (mefloquin) and antitubercular drugs, growth stimulants, harmful contraceptives, hormone replacement therapies and psychotropics.
- A State drug formulary and therapeutic guidelines will be developed, adopted and regularly updated. Use of generic prescribing will be promoted.
- The Directorate of Health and Family Welfare will take responsibility for the drug policy and will not leave it only to the Departments of Petrochemicals or Industry. Forums for intersectoral working will be made functional.
- Pharmaceutical Companies will need to follow nationally and internationally accepted codes of marketing practices, registration and re-registration of drugs for production will also have to follow acceptable norms especially with regard to advertisements, sponsorship, indirect promotional methods, and availability of unbiased information.
- Drug donation guidelines will be developed and implemented.
- fforts will be continued to attain and retain self-reliance in the production of all essential drugs and vaccines. The economy of scale will help these to be available at low cost. Modernization and upgradation of public sector facilities including infrastructure and personnel will be undertaken so that they can contribute to contain drug and vaccine prices and to maintain gold standards.

5.15 Medical Industry (diagnostics, biomedical equipment, health accessories)

The production, procurement and marketing systems for diagnostics, medical equipment, health accessories and educational material will be regulated, keeping in mind need, quality, cost effectiveness, safety and ultimately patient and consumer interests.

There is need for a body to lay down standards and for production to be brought within the purview of a legally binding act. Necessary action will be taken in order to safeguard consumer interest.

- Gender and age disaggregated data to improve the database and analysis of problems, and the impact of interventions. Qualitative and quantitative indicators will be developed and used.
- Special attention will be given to developing counselling and mental health services for women at district and taluk level with trained professionals and by short term training of health workers at primary care levels to respond to needs at community level.
- Facilities for diagnosis and treatment of STDs and RTIs will be made available at the primary care level supported by a referral system.
- Education regarding reproductive health will be given higher priority.

6.3 *Children's Health*

Karnataka State has a special interest in and commitment to the health and well being of children during their intrauterine period, infancy, toddler years, school age and adolescence. Its interventions reach out through MCH programmes, through anganwadis of the ICDS scheme through schools and colleges. A policy document, "The State Programme of Action for the Child" brought out in 1994, reiterated the state's commitments, in keeping with the spirit of the National Policy for Children in 1974, the World Summit for Children in 1990, the four sets of Rights of Children (to survival, protection, development and participation), and the National Plan of Action: A commitment to the Child, adopted in 1992. The State will be guided by the principle underlying the national plan, namely **"first call for children",** wherein the essential needs of children will be given highest priority in allocation of resources at all times. This will also be applied specifically to the spheres of health and nutrition, as recent data reveal unacceptably widespread high levels of undernutrition and anaemia in Karnataka, which leads to illhealth and stunted growth and development. Specific efforts will be made to reach children, especially from socially deprived groups, who are still unreached by the IDCS system and who are out of school. A multisectoral approach will be used to provide services for working and street children, and to address underlying issues that result in their having to work.

- The state will undertake all efforts to **ensure child survival** with no damage to the processes of growth, maturation and development. Continuing efforts will be made to reduce infant and neonatal mortality.
- The coverage and quality of services of the **Integrated Child Development Services (ICDS)** with regard to health, nutrition and care will be improved by providing adequate resources and training of all levels of personnel. Supervisory and monitoring systems will be strengthened. Recognizing the importance of the child care, responsibilities of anganwadi workers, who are volunteers on an honorarium, caution will be exercised in adding additional responsibilities that may be detrimental to their prime responsibility. Constructive partnerships with gram panchayats and parents will be developed and linkages with Primary Health Centre staff will be made more functional and regular. Quality of food given to children will be ensured and health promotion and nutrition education will be undertaken more proactively and professionally. The most needy children, including scheduled castes and scheduled tribes, will receive particular attention. Disaggregated data by age, sex, taluk, and social grouping will be regularly validated and analysed.
- **School health programmes** will be developed, being initiated by the public sector in partnership with parents, voluntary organisations and the private sector. The goal is that a health promoting school will provide a healthy environment, health and nutrition education, school health services,

physical education and recreation/ extra – curricular activities. Through health promotion, preventive health, screening and early detection it helps prevent disease and disability.

School age children account for about 25% of the population. The school health programme will help attain their full potential in physical, psychosocial, emotional and intellectual growth and development. The two-fold purpose is improvement of health and health promotion. Key strategic interventions include training of over 3.15 lakh teachers in the 58,000 schools through a training of trainers; school curriculum review of health related topics; health promotion using activity based learning principles; a focus on life skill education to prepare children for life; ensuring universal coverage with good quality school health services including follow up treatment.

Schools will be seen as community institutions and will be centres from where **out of school children will also be reached.**

- **The adolescent age group has been relatively neglected and currently faces greater risk during this phase of rapid social transition.** Adolescent care and educational programmes will be designed and implemented with sensitivity. These will include family life education, life skill education, basic understanding of sexuality, interpersonal relationships, conflict resolution, coping capacities for dealing with stresses of increasing responsibilities and expectations from others.

6.4 *Mental Health*

The burden of suffering due to mental illness is large. Research work done over the years by premier institutions have helped to quantify this in Karnataka. At least 2% of the population suffer from severe mental morbidity at any point of time and an additional 10% suffer from neurotic conditions, alcohol and drug addictions and personality problems. A large proportion of outpatients (20-25%) in general health services have somatoform disorders and come with multiple vague symptoms. Unsupported and untreated mental illness has an impact on families as well. Mental ill health is thus an issue of public health importance, requiring proactive, sensitive interventions, particularly since more effective and better management is now a reality.

However, there continue to be shortages of trained personnel in Karnataka, compounded by maldistribution of facilities and staff with a greater urban concentration in big cities.

The state will make systematic and sustained efforts to enhance mental health services by:

- Improving training in psychiatry and psychology in the undergraduate medical and general nursing courses.
- Introducing district mental health programmes in a phased manner by strengthening psychiatric teams and services at district hospital level and planning for counselling services at taluk hospital level.
- Ensuring minimum standards of care for mentally ill patients.
- Providing for mental health care at primary care level by training primary health centre medical officers and staff, using manuals already prepared by NIMHANS.
- Encouraging and making provision for care facilities for persons with chronic mental illness, through NGOs and other organizations.
- Introducing the mental health component into school health services on a pilot basis in different districts and later expanding it.

- Supporting broader societal strategies that address violence, particularly against women; discrimination in any form; substance abuse; poverty and destitution.
- Establishing institutional mechanisms at the State level through which mental health care services can be promoted.
- Caring for and nurturing health care personnel, who are carers working under difficult conditions.

6.5 *Prevention and control of non-communicable diseases*

Karnataka and India, along with other developing countries, carry a double burden of communicable and non-communicable diseases. The latter include, in particular cardiovascular diseases, including hypertension, cancers and diabetes. These have on the whole received less public sector and policy attention due to the magnitude of other problems and issues. However with a future perspective, especially considering rising life expectancies, growing urbanisation and industrialisation in the state, and rapidly changing life styles including diets, the state will provide greater support to the prevention and control of non-communicable diseases.

- It will use a public health approach by adopting strategies to reduce the risk factors for these diseases and by using health education to promote healthier life styles.
- It will initiate policies to stem the rapid increase in production, advertisement, aggressive marketing and use of Tobacco and Alcohol products. Over 25 serious diseases are associated with the use of tobacco and several diseases and social problems are linked to alcohol. These are described as communicated diseases. They are both addictive substances and once hooked, their manufacturers are assured of consumers for life, event though for shortened lives. Policies required for their control are broad and include bans on sponsorship of sports and entertainment; bans on direct and indirect advertising; higher taxation; sales to be permitted to only over-18s; sales barred within certain distances from educational institutions; and public education, especially among children and youth as part of life skills education; education of health personnel.

  In the case of ***tobacco***, measures include banning smoking in public places to prevent passive smoking and working towards alternative crops and alternative employment. Chewed tobacco in particular is a growing problem with widespread use among women (40-60% in different groups) and even among children as its addictive nature is not widely known. Comprehensive Tobacco Control includes smoked and chewed tobacco.

  In the case of ***alcohol*** there is a need for strategies to help women and children cope with men who drink heavily. De-addiction strategies using group therapy such as alcoholic anonymous groups will need to be supported, besides individual therapy and counselling.

  Education regarding tobacco and alcohol will be included in school and college curricula.
- Diagnosis and treatment for non-communicable diseases will be made available at primary health care level. This will require preparation of treatment guidelines and supply of diagnostic equipment and drugs.
- Recording and reporting of non-communicable diseases as per the International Classification of Diseases will be introduced into the diseases surveillance system.

- The **cancer control programme** will also be strengthened by tobacco control, health education, early detection and provision of treatment. Facilities will be made available at regional level and later in a phased manner in some districts where medical colleges exist. Grants provided by the national programme will be fully utilised.

6.6 *Disability*

It is estimated that about 2-3% of the total population of Karnataka consists of disabled people with 76% in rural areas and 58% men. Disabilities include locomotor, visual and learning disabilities, hearing and speech impairment, mental illness, mental retardation, multiple disabilities, etc.

An inclusive approach will be used for persons who are differently challenged or persons with disability, with their full participation in decision making and implementation.

The Department of Health and Family Welfare will increase its role and responsibility in respect to disability, which has been largely under the Directorate of Welfare of the Disabled, under the Department of Women and Child Development.

The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act of 1995 will be made more widely known and implemented. Interventions will need to include medical, social and environmental components. The different steps would be:

- Disability prevention — through universal immunization, good nutrition, MCH, accident prevention through drink and not drive policies, helmets for two wheelers and car-seat belts etc.
- Disability limitation – through prompt treatment, particularly at primary care levels.
- Reducing the transition from disability to handicap – by rehabilitation. Establishing rehabilitation units at district hospitals.
- Actively supporting Community Based Rehabilitation.
- Providing access to aids and appliances to those who cannot afford them.
- Using apex and specialized institutions in the state for training of levels of health workers.
- As per the Medical Council of India recommendations, starting Physical Medicine and Rehabilitation departments in every medical college.

6.7 *Occupational Health and Safety*

Though services exist in some large public sector and private sector units, this specialty needs greater support. The focus will be on the agricultural and unorganised sectors who comprise the largest proportion of the work force and who are at risk because few safety devices and precautions are used. The services of institutions like the Regional Occupational Health Centre and experts will be utilised to evolve a strategy.

6.8 *Dental Health/ Oral Health*

Oral health has so far received little policy attention. However, the state recognises that peridontal diseases and dental caries are widespread in the population. These impact on general health as well. Fluorisis is prevalent in certain taluks and districts (North Karnmataka, Kolar, Pavagada). Oral cancers are one of the commoner cancers. The state has the largest number of dental colleges in the country, numbering 41, of which 40 are private. However, there are concerns regarding substandard quality and the lack of impact on oral health in the state.

Karnataka will integrate oral health within its health care services by providing equipment and trained personnel at CHC level and services at PHC level through the medical officers and dental/oral hygienists. School health programmes will have dental/oral health as an important component both for services and health promotion.

6.9 *Emergency Health Services and Trauma Care*

Initiatives to develop this area will be strengthened and expanded. Besides accidents and injuries this will include emergency obstetrics care; snake/insect and dog bites and stings; and other medical emergencies. Existing centres of excellence in the state will be utilised to train expand services statewide. Transport and communication links will be established and 24 hour services provided in selected institutions. Training in first aid and life support systems will be imparted to children, teachers, factory workers, drivers and conductors and paramedics. Preventive measure such as helmets and seat belts will be encouraged. The right of the citizen as determined by the Supreme Court to access emergency care in any hospital and to received the first line of critical care will be publicised.

7. Cross-cutting Policy Issues

7.1 *Medical and Public Health Ethics*

The state is aware of public dissatisfaction and loss of confidence in the health services, particularly of the public sector. The state takes cognizance of expressions of dissatisfaction through the media, elected representatives, people organizations and movements and through the issues of concern raised by the Task Force on Health in its Interim Report. In keeping with its constitutionally mandated responsibility and in collaboration with professionals and the people it represents and works for, it will initiate and make functional institutional mechanisms to provide for checks and balances to protect public interest; and human rights including the right to health and health care.

- The state will promote the principles and practice of **medical ethics** in all its institutions, in all sectors and in all systems of medicine.
- The state will ensure the practice of **public health** ethics in its decision making, resource allocation and in implementation of policies and programmes.

7.2 *Policy Process and Implementation Factors*

The policy document is just one step in the overall ongoing policy process that makes explicit the current concerns, intentions and priorities concerning health by government.

The competence and attitudes of implementers, especially at the point of contact with patients or people is critical in giving life to policies and programmes. Human resource development to develop competencies and capability and caring attitudes will be a priority with a focus on front line implementers and just not on leadership. Energising the primary health centres and all health institutions is our goal. Good communication, supportive supervision, regular updates, small group work, decentralistion of decision making and financial powers, participatory methods, better governance and accountability systems, along with strategic planning at all levels will be the strategic approaches to better implementation.

Strong politico-economic and social forces also influence implementation in directions most often against the interests of the poor and marginalized groups.

These include professional bodies and interests; industrial and business interests of pharmaceutical,

diagnostic and medical equipment manufacturers; the media; donor agencies; International agencies and others. On the other hand, patients and people, particularly the poor, are relatively unorganized and most often unheard in the policy process. The state recognises that it represents this public interest and it commits itself to undertaking this responsibility to improving health and health care of its citizens.

8. *Conclusion*

In conclusion, through this policy document Karnataka state is placing health high on its agenda. It reaffirms the wisdom of the sages who said that health is wealth. It will translate this into action by allocating adequate human and financial resources, by good governance and institutional capacity building. "Better health for all now" can only be achieved if it is seen as a common endeavour of all sections of society. The state will play a facilitating role in harnessing resources, energies and ideas from the private and voluntary sector. It will stay committed to its mandate and will work towards equity, integrity and quality in health and health care.

Recommendation

- *The draft Integrated Health Policy should be adopted after dialogue with Directoarte of Health and Family Welfare Services, other Government Departments, Voluntary Organisations and the Public.*

of patients, the citizen's charter and the Right to Information Bill. Increasing emphasis on ethics and integrity in the training programmes, better governance, supervision and creation of the vigilance cell will all help in reducing corruption in health care services. The balancing role of civic society organisations will be encouraged by involving people's organisations, NGOs and elected representatives in various capacities.

Action taken with respect to recruitment, postings and transfers of doctors and others has reduced corruption. These steps will be continued.

There were many complaints of corruption by examiners in University examinations. Action by the University to remove such examiners has produced the desired results.

8. Community Participation

One of the requirements for improved primary health care is community involvement. There is greater degree of participation of the people in all matters affecting health and health care. This has been helped by the institution of health committees from the village level onwards.

9. Water Supply and Sanitation

By 2020, we envisage complete coverage of the entire population with safe potable water supply, and coverage of 80% of the population with sanitation facilities, through an intersectoral effort.

There is improvement in water supply, an important determinant of health. The Bangalore Water Supply and Sewerage Board and the Karnataka Water Supply and Drainage Board are working towards improved water supply in cities and towns. The Department of Rural Development and Panchayati Raj is spearheading service provision in rural areas, supported by a variety of externally assisted schemes. There is also improved supply of drinking water, both in quantity and quality, through the activities of the panchayats and village committees. There is better monitoring of drinking water supply by the Health Department, using simple devices and improved chlorination and other measures to assure better quality. These will be carried out by the male health workers who are trained for the purpose and the work will be supervised. The scarcity of water is tackled by better harvesting of rainwater and better management of surface water, bore wells and hand pumps, Fluorosis and other problems are also being tackled.

Sanitation receives greater attention in the cities, towns and villages. This includes disposal of garbage, sewage and human and industrial waste. There are more latrines but not sufficient. People are encouraged to have sanitary latrines attached to their dwelling places, instead of women having to wait until its is dark to relieve themselves in the open.

Hospital wastes are receiving greater attention, with segregation of the waste and appropriate disposal.

10. Environment

Everyone has the right and responsibility to live and work in healthy environments. Many people, especially those living in urban slums are compelled by circumstances to live in un-sanitary conditions. The situation becomes worse in rainy seasons. The slum dwellings are often below the road level and filthy water flows into the houses. Work environment particularly for the unorganised and small-scale sector is suboptimal. Housing, living and working conditions have to improve, through the efforts of all sections of society enabled by the state. Bodies set up by the state will also look at action required at state level to study and respond to broader environmental issues as depletion of the ozone layer; global warming; air, water and soil pollution; and others; all of which impact on health.

11. Nutrition

The percentage and absolute numbers of severely and moderately undernourished children will be significantly reduced, as a result of better nutrition awareness and action. Mid-term goals stated in the health policy document will be improved by a further 50% by 2020.

12. Immunisation

There are many achievements by 2020. There is better coverage of children under the Universal Immunisation Programme. Paralytic polio has been eradicated. The number of vaccine preventable diseases is reduced. However coverage is still incomplete, especially in backward districts. There are still problems of maintenance of cold chain with frequent breakdown of electric supply. There is need for dependable refrigeration system. By 2020, this basic preventive health strategy will have universal coverage with good quality.

13. Transition Stage

Karnataka is still in the epidemiological transitional stage. It still has a large share of infectious diseases, characteristic of the underdeveloped world, as well as the degenerative and other diseases of industrialised and affluent societies. The old scourges of tuberculosis and malaria continue. It is envisaged that by 2020 the burden of preventable infectious diseases will be contained keeping alert to newer and re-emerging diseases that continue to remind us of the need to address deeper underlying socio-cultural, behavioral and political economy factors. Health promotion regarding risk factors and healthier lifestyles will be actively undertaken with creativity, professionalism and broad based participation.

HIV infection has been contained to some extent; anti-retroviral drug combinations are being used against HIV infection.

14. Medical Services

Primary, Secondary and Tertiary Care Services are available through Public, Voluntary and Private Sectors. But there are problems due to commercialistion of medical care. With a middle class mindset, policy and decision makers do not see the needs of the poorest of the poor. With globalization of medical care, the cost of care has gone up. The affluent can afford the care but the very poor continue to be outside the medical care in the private sector. There is need for social security, ensuring that the poorest can get the needed medical and health care.

15. The Non-Communicable Diseases

The non-communicable diseases are on the increase. Diabetes Mellitus continues to be a serious condition. A very large number of people are affected in urban and rural areas. 8-10% of males and females of 20 to 80 years are affected. The disease leads to many complications. Management and control of blood sugar level are absolutely essential.

High blood pressure is also prevalent in a large proportion of the population. Cardio-vascular diseases are very common. Primary, secondary and tertiary prevention are necessary; changing life styles have added to the problem. The state has a large number of patients with asthma and chronic bronchitis.

16. Cancer

There is not enough community-based data on the prevalence of cancer in the State. Cancer registry data may not reflect the true cancer situation. Changes in life style, longevity and use of tobacco in various forms are some

of the important causes leading to increase in cancer. The increase in treatment centers has not been able to cope with the demands.

17. Sight for all

The number of the visually impaired continues to be high. The major cause (80%) is cataract. This is curable. It is unfortunate and unacceptable that Karnataka has not been able to cope with the need for cataract surgery (mostly intraocular lens implantation) even though we have the required trained eye surgeons and the cost of IOL has come down drastically. Other causes of impaired vision like corneal ulcers and opacities, glaucoma, refractive error, trauma and diabetic retinopathy continue. Vision 2020 works towards coverage of the backlog, with attention paid to other.

18. Substance Abuse

Alcohol consumption continues to be high, resulting in various kinds of diseases, affecting almost every organ of the body. Not enough is being done to reduce the demand or supply of alcoholic drinks and the harmful effects from their abuse.

Tobacco is another substance which has widespread harmful effects on the body, including cancer, cardiovascular diseases and other problems.

19. Indian Systems of Medicine

Not enough is being done to improve the functioning of the health care institutions belonging to the Indian Systems of Medicine. The people continue to use the systems of Ayurveda, Unani, Siddha, Homoeopathy, Yoga and Naturopathy.

Herbal medicine is very popular.

Other healing practices such as Tibetan Medicine, acupuncture, acupressure, pranic healing, Reiki, magnetotherapy and many others continue to be popular with the public.

20. Panchayat Raj

There is greater co-operation between the Panchayat Raj Institutions and Health Services. The Panchayat Raj Institution members are more aware of their responsibilities and powers. They are involved in the planning and implementation of the development programmes including health at various levels. This is making a substantial impact on the improvement of health services at the periphery.

21. Medicinal drugs

The use of drugs has become more rational. Most of the essential drugs are available at the health care institutions in the public sector. But some of the drugs, under the new patent laws are not easily available because of the increased cost. The patent laws have affected the production of some of the drugs in the country.

22. Informatics Technology

Karnataka has made vast strides in Informatics Technology and this has made its impact on Health Care. There are four main areas where informatics technology can be useful.

- Patient care (diagnostic and therapeutic decisions)
- Medical education, training and research
- Public health
- Health Systems management.

Patient care, both diagnostic and therapeutic, has benefited from telemedicine in secondary and tertiary care with cardiac monitoring and ECG evaluation via a telephone line. ECGs and sonograms are transmitted to experts and their advice obtained. It can be expected that these facilities will be extended in due course to primary health care in remote areas. Computerized ECGs, stress test equipment and scanners can be linked to computer networks and opinions of experts (situated in the cities) can be obtained.

Medical education can benefit from computer assisted instruction. Visual information (images) can be very useful. Computer animation can be added to it. MEDLARS has been helpful in promoting education, training and research in health.

Health Management Information System has been developed and has been in place for some time. It helps in better management of health care systems. Hospital Information System has also been developed. Improving the utilisation of the facilities available and bringing out lacunae and mismatches.

Public health can benefit enormously. Disease surveillance has been computerized. Early information leads to early and effective interventions and containment of disease out breaks.

The vision is promising. The need is to have a mission to achieve that vision, where there is equity, integrity and quality in health and health care.

KARNATAKA VISION 2020			
Indicators	**2001 (Source / Year)**		**2020**
Infant Mortality Rate	58 / 1000 live births	SRS 1999	25 / 1000 live births
Under –5 Mortality Rate	69 / 1000 live births	NFHS – 2	35 / 1000 live births
Crude Birth Rate	22.3 / 1000 population	SRS 1999	13 / 1000 population
Crude Death Rate	7.7 / 1000 population	SRS 1999	6.5 / 1000 population
Maternal Mortality Rate	195 / 1,00,000 live births	SRS 1998	90 / 1,00,000 live births
Life Expectancy at Birth			
Male	61.7 years	1996-2001	70.0 years
Female	65.4 years	1996-2001	75.0 years
Total Fertility Rate	2.13	NFHS – 2	1.6
Percentage of Institutional Deliveries	51.1	NFHS – 2	75
Percentage of safe deliveries	59.2	NFHS – 2	> 95
Newborns with Low Birth Weight	35 %	1994	10%
Percentage of mothers who received ANC	86.3	2000	100
Percentage of eligible couples protected	59.7	2000	70%
Percentage of children fully immunised	60	NFHS – 2	90
Anaemia among children (6 – 35 months)	70.6%	NFHS – 2	40.0%
Nutritional Status of children			
Severe under nutrition	6.2%		2.0%
Moderate under nutrition	45.4%	Gomez, 1996	25.0%
Mild under nutrition	39.0%		43.0%
Normal	9.4%		30%
Sex (Gender) ratio	964F / 1000M	2001 census	975F / 1000M
Sex (Gender) ratio, 0-6 years	949F / 1000M	2001 census	970F / 1000M

24. IMPLEMENTATION OF THE REPORT

The Task force had the unique opportunity of considering the entire health system of the State. Consequently, the recommendations of the Task Force are wide ranging and impact on almost all aspects of the health system. At first sight the recommendations may seem too many and too detailed. However, it would be evident that in the effort to cover all aspects of the health system, all issues had to be considered and inter-relationships both within this system and the links with other social and development activities had to be included. Obviously, it would be necessary while considering and implementing these recommendations to prioritize them by urgency for change, feasibility within a set time frame and need to ensure a smooth transition. The recommendations could be broadly said to consist of three types.

- Those that relate to the changes in the basic structure of the health services and involve formulation of new Cadre and Recruitment Rules and associated elements;
- Those that relate to "governance" issues such as training, morale building, transparent transfer polices; personal appraisal system, monitoring of finances, administrative and technical aspects of work; disciplinary systems; relationship with the Panchayat institutions and other elements of management;
- Those that relate to enhancement of equity, quality, integrity and coverage and building in emphasis on new elements in the health services provided. These include the elements such as expansion and addition of services, better surveillance, better access and reach of services, reduction of disparities and the like.

It must be emphasized that these are not exclusive. On the other hand, they are inter-connected since they together seek to re-engineer the health system for higher efficiency and productivity and greater equity. However, these three sets of recommendations would need special expertise appropriate to the character of the category of recommendations. Such expertise would range from administrative, financial, legal and management experience to knowledge of the professional content of both public health and medical (clinical) services. The structures for examination of the recommendations would, therefore, have to be based on these special requirements. A two-tier structure is suggested for this purpose. The first could be an **Implementation Committee.** The second would be subject matter **Sub Committees** whose reports would be considered by the Implementation Committee and, in due course, by the final decision making level in Government.It is suggested that the recommendations be considered by an official Implementation Committee (for Health Systems Reform) which could include:

Principal Secretary for Health & FW, Secretary Medical Education, Commissioner for Health, Director, KHSDP, who has been Member Secretary of the Task Force, Secretary Department of Personnel and Administrative Reforms, Director, Health & FW representative of the Finance Department and a representative of the Law Department.

The Implementation of recommendations for change is essentially the responsibility, the prerogative and the privilege of the Department of Health and Family Welfare. It is to be done in an atmosphere of freedom, innovation and creativity. The government need to provide the department with the best officers to lead and steer this important and challenging process of change, ensuring them adequate time, space and support. The Task Force has refrained from detailing implementation plans but expresses its willingness to be a sounding board in this regard, if required.

To initiate implementation of the recommendations at the earliest, a **small core group** of young energetic doctors be selected to function under the Commission for Health to study the recommendations and evolve plans. This group could function on a short-term basis. The work would be later continued by the Planning and Monitoring Division. The Core group may first process the recommendations for consideration of Government, prioritize them and set realistic time frames for implementation. Some of the recommendations can be implemented early by the Department. The attempt must be to expedite the process of implementation. Therefore, the time frame should be as short as possible.

Other experts could be co-opted for specific issues by the Implementation Committee or the Sub Committees.

The Implementation Committee would need the assistance of a small but efficient secretariat, by way of a Cell, to process the recommendations, prepare notes for the Committee and the Sub Committees and follow up all action points. It is recommended that this cell be constituted of full time officers drawn from within the Department and other connected Departments. Expertise from outside could also be inducted with advantage.

The number of such officers and experts and the supporting staff may be determined and the positions filled by selection of capable persons. This cell may be placed under the Commissioner and will function till the Planning and Monitoring Division is fully established.

The Implementation Committee could set up Sub Committees for specific aspects. Priority would have to be given to the reorganization of the health services. This would include basic issues such as setting in place through Government orders the suggested system, transition provisions, establishing the District Cadres and the procedures for allocation of existing personnel and future recruitment procedures, preparation of the separate seniority lists for the two Cadres of Public Health and Medical, determination of time scales for those who prefer to remain as doctors at the PHC level, preparation of the new Cadre and Recruitment Rules, etc.It would be useful to list out all these issues and develop a calendar of operations, with specification of the Sub Committees that would deal with each issue. It must be reiterated that the effort should be to implement the recommendations in as short a time frame as possible. If these recommendations are implemented, there would be little doubt of the future of the health services of the State in terms of efficiency and professional excellence and, most important of all, ability to serve the people of the State to their full expectations and satisfaction.

The woods are lovely, dark and deep,
But I have promises to keep
And miles to go before I sleep,
And miles to go before I sleep.

- Robert Frost

25. MAJOR RECOMMENDATIONS AND EXPECTED OUTCOMES

"Our main business in life is not to see
what lies dimly at a distance
but to do what clearly lies at hand"

- Dale Carnegie

The Task Force on Health and Family Welfare had made some short-term recommendations to improve health of the people and strengthen health care services in Karnataka, with special focus on Primary Health Care and Public Health. The Task Force is happy that these short term recommendations have found acceptance by the Government and many of them have been implemented or, are in the process of implementation. The Final Report takes cognisance of the acceptance of the short term recommendations and builds on them with the medium and long term recommendations. Implementation of these recommendations would yield good dividends by way of improved health and human – centred development.

The overall thrust of the short term recommendations had been **Equity With Quality**. These continue to be the major thrusts. During discussions with various groups and individuals, and observations in the field, another important focus became clear: **Integrity.** It deals with corruption which is widespread and must be tackled. There is increasing corruption in health services; if the newborn baby is to be seen by the mother or close relatives, a bribe has to be paid. If an operation is to be done, a bribe is demanded. It is true that there are many, many health professionals and health workers who do their work honestly. But there are others who are unethical in their practice and hold the public to ransom.

The hallowed precincts of theUniversity and teaching institutions are not free of this lack of integrity. Bribes are demanded if a pass is to be given. Even a good student has to pay to ensure that the he/she does not fail.

But integrity goes beyond these. It deals with *failure to do one's duty*. **Non-performance** has come out as a major issue.

There have been failures of the individual and the system. There is need for improvement. Better training and overall capacity building can help in improved performance; so also, reorganisation of the services can help in the utilization of resources with better accountability.

There are a large number of recommendations given under each chapter or subchapter. These are all important. But in order to highlight the more important recommendations, they have been brought together as "Major Recommendations". We have also given the expected outcomes" against each recommendation, even though, in the majority of the recommendations, the outcomes are self-evident within the recommendations themselves.

Sl.No.	Major Recommendations	Outcome expected
	1. EQUITY IN HEALTH CARE	
1.1	*All policies of the Government (State and local), likely to have direct or indirect effect on health, should be governed by the principle of equitable access to effective care to meet the needs of the people; they should be formulated such that disadvantaged are addressed to reduce inequity. Monitor inequities in health based on social, economic and health care services, disaggregated with respect to age, gender, socio economic status, geographical regions and others.*	All people have equal opportunity to meet their health needs.
1.2	*The Health System must improve availability and access to quality health care (particularly primary health care and public health) in the underserved talukas / districts and for the poor and vulnerable population. Ensure better utilization of the primary health care services by making the facilities fully functional and people friendly and through monitoring and supervision improve the quality of service.* *The State Government and the local governments should take special steps to bring up the health status in areas where the health status is below the State average.*	Quality health care is available to the poor and the disadvantaged and in underserved areas, considering talukas and districts as the base
1.3	*In the large and undivided districts like Gulbarga and Belgaum the districts should be divided into two and a post of Additional DHO / DMO should be created with additional team of Programme Officers.*	The quality of health care will improve with better supervision.
	2. QUALITY OF HEALTH CARE	
2.1	*Have minimum acceptable standards worked out by independent committees for health care institutions at different levels and locations and for public health measures.*	Standards are worked out for health care institutions at different levels and locations and for public health measures.
2.2	*The Joint Directors, Medical and Public Health, will be designated as the persons in charge of Quality Assurance. The Administrative Medical Officer in charge of each hospital will be responsible for ensuring quality of care in each institution.*	Nodal officers and administrative medical officers assigned the responsibility for quality assurance will be held accountable.

Sl.No.	Major Recommendations	Outcome expected
	3. PRIMARY HEALTH CARE	
3.1	*Have the philosophy of comprehensive primary health care accepted through training and advocacy and implemented by all concerned: the people and the health services.*	Priority is given to comprehensive primary health care, as distinct from selective primary health care and in preference to secondary and tertiary health care.
3.2	*All existing vacancies of doctors, nurses, pharmacists, laboratory technicians and ANMs in the primary health centers and subcentres must be filled up immediately. Appointments made on contract basis must be regularized. Have regular appointments made based on needs for which there must be a continuous assessment and monitoring of vacancies likely to occur in the PHCs&subcentres.*	All posts at PHCs and subcentres are filled up promptly with qualified personnel, appointed regularly, improving service.
3.3	*Appoint staff nurses at all PHCs, creating posts where there are none at present.*	Qualified staff nurses are available regularly.
3.4	*All essential staff, including doctors, pharmacists, nurses and ANMs attached to the Primary Health Centres must stay at headquarters.*	All essential staff are available for service at all times.
3.5	*Have a construction and renovation programme such that every PHC will have a suitable building within the next 5 years and quarters for the essential staff within the next 10 years. In the interim period, take suitable buildings on rent for PHCs and staff quarters.*	Every PHC will have its own building over a time frame. Buildings will also be available for the stay of all essential staff.
3.6	*Consider the possibility of making available rural medical practitioners / physician assistants / nurse practitioners / nurse obstetricians available for service in the rural areas, where qualified MBBS doctors are not available.*	Where MBBS doctors are not available for service at PHCs, other trained practitioners are available.
3.7	*Have telephones at the PHCs installed without delay for better communication. Make arrangements for the speedy transport of patients to the referral centers by provision of ambulance vans or funds to hire available transport, in the case of the poor.*	Communication and transport are assured
3.8	*There is need to have fully functional laboratory services, with trained technicians.*	Diagnostic services are assured

Sl.No.	Major Recommendations	Outcome expected
3.9	*Have Village Health Committees at Gram Panchayat level. Two representatives each of the committees will be members of the PHC level co-ordination committees, which will have representatives of voluntary organisations, professional bodies and elected representatives. The Department of Health must stipulate the working hours of PHCs and subcentres to suit the community needs.*	Community involvement is assured at the village and PHC levels. More convenient working hours of PHCs.
3.10	*PHCs must have round the clock service. Make available the services of Lady Medical Officers. Progressively increase the number of lady medical officers at PHCs such that, in the course of the next 10 years, every PHC will have one male and one female medical officer.*	PHCs must provide round the clock service. The services of lady medical officers are assured.
3.11	*An appropriate referral system and linkages between PHCs and Secondary Care Institutions must be put in position to make primary health care more efficient and effective.*	An efficient and effective referral system is in place.
3.12	*Have Urban Primary Health Centres, one for 50,000 population in cities and towns, converting the existing resources such as health centers, urban family welfare centers and maternity homes. While these Urban Primary Health Centres will be the responsibility of the local body (Corporation or Municipality), technical guidance will be provided by the Directorate of Health and Family Welfare Services.*	Comprehensive primary health care in urban areas comes to function, administratively under the local bodies, with technical guidance from the Department of Health and Family Welfare Services
3.13	*Every PHC will display prominently a Charter of Rights of patients and citizen's charter.*	Greater transparency and better appreciation of the rights of patients are assured.
3.14	*Distribute the male health worker, one for each Gram Panchayat, redefining his job responsibilities. He will belong to the District Cadre. The technical control will be with a designated PHC medical officer.Or Male Health Worker could be given the responsibilities of 2 Subcentres.*	Better utilization of the services of male health workers with defined responsibilities.
3.15	*Reorganise and restructure the PHCs, PHUs and subcentres (including staffing) considering the population and area covered and accessibility.*	Improved functioning of PHCs, PHUs and subcentres.
3.16	*Provide interest free loans for the purchase of two wheelers for the transport of Medical Officer and health workers at PHCs and subcentres.*	Improved mobility and availability of functionaries at the first contact level.

Sl.No.	Major Recommendations	Outcome expected
	4. SECONDARY AND TERTIARY HEALTH CARE	
4.1	**SECONDARY AND TERTIARY HOSPITALS**	
4.1.1	*Make the secondary and tertiary health care institutions fully functional, with the required staff (avoiding mismatch) and equipment in good working condition. Appoint an expert committee to examine the needs of the State with respect to the specialities and their rational distribution in the districts and talukas, together with requirements of personnel, equipments, etc.*	The needs of the people for secondary and tertiary care are better met.
4.1.2	*Make the hospitals under the Indian Systems of Medicine and Homeopathy function well. Standards for these hospitals must be worked out and implemented.*	The hospitals under ISM&H provide quality care.
4.1.3	*Steps must be taken during training (in-service) programmes to inculcate the feeling of 'ownership' of the hospitals by the staff at every level, with good 'supervision' and 'facilitation'.*	Improved functioning of the hospitals.
4.1.4	*CHCs need the post of anaesthetists for the functioning of the Departments of Surgery and Obstetrics & Gynaecology*	Improved surgical, obstetric & gynaecological procedures.
4.1.5	*The equipments must be maintained in good working condition; the downtime must be reduced to the absolute minimum.*	Better utilization of the equipments
4.1.6	*The Administrative Medical Officer must be trained in Hospital Administration.*	Improved hospital administration; better service to the patients.
4.1.7	*The Secondary Care Hospital must have a social worker and a Dharmashala for the care of the patients and attendants.*	Improved facilities for the patients and better patient satisfaction.
4.2	**EMERGENCY HEALTH SERVICES**	
4.2.1	*Develop Emergency Medicine and Trauma Care Centres to provide comprehensive medical care, including medical, surgical, obstetric, paediatric and trauma care. To start with there will be 44 such centers developed by the Karnataka Health Systems Development Project. This will be expanded gradually to include more hospitals, spread throughout the State. Each center will have 10 beds for emergency medicine and trauma care. The Centres will have trained personnel, all necessary equipment and furniture.*	Improved emergency care, reducing death, disease and disability.

Sl.No.	Major Recommendations	Outcome expected
4.2.2	*A good and working communication system will be developed. This will include telephone facilities and wireless sets. Well-equipped ambulance services with trained personnel will be provided. The help of the police will be taken to ensure early and easy communications. A system of community insurance will be developed.*	All available delay is removed. Patients get the best possible care at the earliest.
4.2.3	*Helmet wearing should be made compulsory for two wheeler users (including pillion riders). Seat belts should be worn while driving cars. First aid training should be mandatory to drivers and conductors of buses, trucks and other vehicles. These vehicles will carry functional first aid boxes.*	Improved safety on the roads.
4.2.4	*The Additional Director, (Medical) will be the Chief Nodal Officer for coordinating all work with respect to Emergency Medicine and Trauma Care.*	A designated person is given the responsibility for co-ordination.
4.3	**DIAGNOSTIC SERVICES**	
4.3.1	*The Public Health Institute must be redesigned and strengthened to encompass Epidemiology and laboratory components. This State Level Laboratory should have expertise in Bacteriology, Virology, Mycology, Parasitology, Medical Entomology and Toxicology. Its functions include Supervision, Training, Quality Management, Reagent preparation and Standardisation.*	A State level laboratory with necessary expertise and facilities is available.
4.3.2	*The District Hospital Laboratory and the District Health Laboratory will be integrated; the District Laboratory will fulfill both functions – diagnostic service for health care, and for public health. The District Laboratory should be supervised by one MD / DCP (Microbiology) and MD / MSc (Biochemistry) and one MD / DCP (Pathology), and adequate respective staff, technical and administrative. The Taluk Hospital Laboratory should be supervised by one specialist of DCP qualification, supported by other staff. CHC and PHC laboratories will be managed by Trained Technicians.*	District, Taluka and PHC level laboratories are provided.
4.3.3	*Imaging and miscellaneous investigative services will be provided to meet the requirements for diagnostic tests at various levels.*	Imaging and other diagnostic services are available according to needs and feasibility.

Sl.No.	Major Recommendations	Outcome expected
4.4	**BLOOD BANKING AND TRANSFUSION SERVICES**	
4.4.1	*All blood banks should have the required equipment, and be supplied with adequate reagents and testing kits in a timely manner. They should have adequate number of trained staff. All blood banks should put in place a quality assurance programme.*	All blood banks are of the required standards and quality.
4.4.2	*A comprehensive plan to motivate and mobilize voluntary and relative blood donors to ensure adequate supply of safe blood throughout the year and all over the state should be developed with their help.*	Availability of safe blood is assured
4.4.3	*The medical community should be sensitized to make optimal & rational use of blood. Every hospital should have a blood transfusion committee to ensure this.*	Optimum use is made of the blood.
4.4.4	*A pilot project to study the logistics, management and monitoring of the centralized 3-tier system comprising – "Blood Component Center- blood collection -blood storage & issue points" should be initiated in Bangalore; and this model replicated later in other major cities, if found feasible.*	Information on management of the blood banking system becomes available.
4.4.5	*An adequate number of well-equipped (Whole Blood) blood banks will have to be set up, keeping the blood needs and regional disparities in mind.*	A system is in place to provide for the requirement of blood throughout the State.
4.5	**BIO-SAFETY**	
4.5.1	*Radiation Protection programmes must be strictly followed by the X-ray equipment users.*	Health professionals and patients will be protected from radiation hazards.
4.5.2	*Adequate consumables for barrier protection like aprons, masks and gloves should be provided to staff.* *All health care workers who are at potential risk for infections which may be transmitted through blood and body fluids should be immunized against Hepatitis B.*	Health professionals and patients will be protected from nosocomial infections.
	5. PUBLIC HEALTH	
5.1	**PUBLIC HEALTH AND PRIMARY HEALTH CARE- A SYNERGY**	
5.1.1	*All the staff of the Department of Health and Family Welfare Services must appreciate the importance of Public Health and the synergy between primary health care and public health.*	Public Health is given due importance.

Sl.No.	Major Recommendations	Outcome expected
5.2	**WATER AND SANITATION**	
	While other departments are responsible for storage, treatment and distribution of water, the department of health, has specific responsibilities for monitoring quality.	
5.2.1	*Set standards for water quality and ensure regular testing to ensure that they are maintained. This information should be made available to the public.*	Standards are set for quality of water and periodically monitored.
5.2.2	*Undertake, supervise and be responsible for water purification treatment e.g. chlorination of wells in rural areas by junior health assistants in collaboration with the panchayats / local bodies. Undertake periodic testing for microbial contamination. New water sources will need an initial detailed testing for chemical contamination.*	Junior health assistants carry out periodical testing, chlorination and other measures.
5.2.3	*Undertake surveillance and notification of the concerned authorities regarding early outbreaks of waterborne diseases, as part of the disease surveillance system. Initiate rapid action in suspected outbreaks.*	Waterborne diseases are controlled.
5.2.4	*Integrate health promotion activities concerning water and sanitation related problems at all levels - through schools, panchayats, women's sanghas, the print and audio visual mass media and folk culture groups. The linkage between health status and water supply, sanitation and drainage needs to be highlighted. Positive messages regarding personal hygiene practices, environmental hygiene and how to utilise government schemes.*	Health promotion activities with respect to water and sanitation.
5.2.5	*Ensure availability of toilets in schools and public places and in individual households.*	Improved sanitation, with decrease in water borne diseases.
5.3	**POLLUTION AND WASTE MANAGEMENT**	
5.3.1	**General Waste Management:** - Set up a working group to look at the recommendations of the Supreme Court Committee for management of solid waste in Class I cities and draw up an Action Plan for implementation in Karnataka. - Learn from experiences in Bangalore regarding primary (door-to-door) collection of garbage and expand it to the other cities and towns. - Accelerate the process of identifying and utilising the Landfill sites. - Delineate the elements of an Integrated Waste Manage-	A policy for waste management becomes available and action taken to dispose off solid waste.

Sl.No.	Major Recommendations	Outcome expected
	ment Policy at the State Level. - Identify mechanisms for improving the functioning of the local self-governments with regard to Solid Waste handling (Financial and Technical expertise including). - The government should provide certain common facilities like collection & transport, incineration, sanitary landfill sites etc., for all Towns and Cities and support private initiatives for common waste management facilities including recycling units.	
5.3.2	**Hazardous Waste** - Steps to be taken to publicise and bring in greater transparency in the functioning of the State Pollution Control Board including the punitive measures taken against the polluting industries. - Set up the working group to examine the existing provisions of the Environment related acts (Water Act, Air Act and Environment Protection Act) and the impact of the 73rd and 74th Amendment to the Constitution of India (Nagarapalika and Panchayath Raj Acts). - Regulate the use of Plastics including the implementation of the ban on plastics less than 20 microns thick. - Steps to be initiated to regulate the use of Mercury and other heavy metals in industries.	Pollution of the environment reduced.
5.3.3	**Natural Resources depletion and Pollution abatement:** - Study the recommendations of the Eco-committee report under the chairmanship of Sri A N Yellapa Reddy and draw up of an Action Plan for implementation. - Health Impact Assessment to be made mandatory along with Environment Impact Assessment for developmental projects. Initiate steps to address the abatement of indoor air pollution within households (efficient and effective use of firewood and other fossil fuels; popularising the use of LPG).	Reduction in pollution. Development projects are cleared after considering their impact on health.
.3.4	**Bio-Medical Waste** - The Andhra Pradesh experience (Task Force for independent monitoring and reporting), and Tamilnadu experience (Development of Model centres in each district) towards development of systems for safe management of health care waste to be studied and appropriately incorporated into the working of the Advisory committee to the Appropriate Authority on Bio-medical Waste Rules in Karnataka.	Bio-medical waste disposal is improved after learning from our own and neighbouring States experiences. Health care personnel are trained in proper separation and disposal of waste.

Sl.No.	Major Recommendations	Outcome expected
	- The waste management initiatives at the KHSDP Hospitals should be strengthened and extended to all health care institutions. - Ensure proper segregation of waste and total waste management at all health care institutions. The segregated waste streams should not get mixed up with general solid waste. The segregated waste should be disinfected; sharps should be destroyed / disfigured and plastics shredded before final disposal through discharge into sewage systems, land-fills etc. Recyclable material should be sent for recycling. Ensure training of Healthe Care Personnel for proper waste management practices.	
5.4	**COMMUNICABLE DISEASES**	
5.4.1	**VECTOR-BORNE INFECTIOUS DISEASES**	
5.4.1.1	*Establish programmes for control of all vector borne diseases, including Malaria, Filariasis, Japanese Encephalitis and Dengue fever / Dengue Haemorrhagic Fever and Dengue Shock Syndrom, and KFD. Emphasise bio-environmental methods of control.*	Control of vector borne diseases.
5.4.1.2	*Establish a District Level Disease Surveillance System and a State Level Diagnostic and Reference Laboratory for mosquito borne infections and other communicable diseases of public health importance.*	Control of communicable diseases
	Kyasanur Forest Disease	
5.4.1.3	*Strengthen the existing disease surveillance system for Kyasanur Forest Disease with every case of human infection or monkey death being reported and investigated.*	Early detection of outbreak of KFD.
5.4.1.4	*Vaccination of the population at risk. Production of adequate quantities of KFD vaccine must be ensured as also timely supply through cold chain.*	Prevention of KFD.
5.4.1.5	*The latest method for diagnosis like ELISA test should be introduced for quick and correct diagnosis.*	Improved and early diagnosis.
5.4.2	**TUBERCULOSIS**	
5.4.2.1	*The quality of implementation of the Tuberculosis control programme in all districts, including urban areas, under both the National Tuberculosis Programme (NTP) and*	Improved diagnosis and care.

Sl.No.	Major Recommendations	Outcome expected
	the RNTCP needs to improve within the next year. All staff involved will need to be held accountable for performance. The primary health centres should provide access to good quality TB care for all, and should have - *laboratory technicians, whose skills are updated and whose slides are cross checked regularly;* - *microscope, stains, all records and registers;* - *uninterrupted drug supplies;* - *medical officers are trained by the District TB officers regarding the organisation and functioning of the NTP/RNTCP;* - *close supportive supervision from the taluk health officer and DTC in particular with problem solving in the field.*	
5.4.2.2	*The District TB Centre should have a qualified person in public health or with a diploma in TB and chest diseases. DTOs should undergo the training at National Tuberculosis Institute (NTI). Two medical officers are required at the DTC – one to run the clinical service and the other to undertake training in the field and to analyse reports etc. The DTC is the referral centre for all aspects of the NTP/ RNTCP and should undertake orientation and training of institutions and General Practitioners in the private, voluntary and public sector regarding the programme. A medical college department cannot replace the DTC.*	The District TB Centre becomes functional and effective.
5.4.2.3	*The state should work towards* - *Increased case detection to 75% of expected cases. This will include cases detected by the public, private and voluntary sector for which a system of notification may be required. The expected number of cases may also have to be recalculated based on recent epidemiological data. Targets should not be used.* - *Early case detection, with emphasis on sputum microscopy for diagnosis. The use of x-rays should be rationalised to reduce over diagnosis and unnecessary treatment. There should be an acceptable ratio between sputum positive and sputum negative cases (1:1).* - *Completion of treatment with cure rates (measurable in sputum positives) of at least 85%. Two drug regimes should be discontinued.*	Improved case detection and completion of treatment.

Sl.No.	Major Recommendations	Outcome expected
	• *Recording, reporting and analysis at DTC level to be used for monitoring and planning the programme.* • *Paediatric dosage forms of drugs to be made available. Anganwadis could be centres for follow-up of young children with TB.* • *Supervised or directly observed therapy to be used only when necessary. Active involvement of patients and their families in the treatment process with adequate patient education.*	
5.4.2.4	*The State TB Centre to be a model centre that is also used for training and operational research, including social science research into patients and peoples' perspectives. Networking and training with NGOs and the private sector to be facilitated by this unit along with the Karnataka State TB Association.*	The State TB centre conducts training & research.
5.4.2.5	*The state should make greater use of the services and advice of the National TB Institute.*	Services of NTI used better.
5.4.2.6	*Given the co-infection of HIV and TB, training for physicians and health personnel regarding specifics of presentation, access to treatment, developing working links with the Karnataka State AIDS Society.*	Health personnel trained for tackling co-infection.
5.4.2.7	*The State TB Society should include professionals and NGOs and regularly (annually) review the implementation of the programme.*	More effective functioning of the State TB Society.
5.4.3	**VACCINE PREVENTABLE DISEASES**	
5.4.3.1	*Review periodically the Immunisation Policies and Practices with the help of experts. Establish Disease Surveillance System to measure the outcome of the Universal Immunisation Programme. Any occurrence of vaccine-preventable disease, especially in a cluster of two or more cases, must immediately attract public health attention, and improve vaccination coverage locally*	Improved planning, monitoring and evaluation of the Universal Immunisation Programme
5.4.3.2	*Include Hepatitis B vaccine, under Universal Immunisation Programme for the immunisation of children.*	Protection of children from Hepatitis B infection.
5.4.3.3	*Production of vaccine in the State to be modernized using the latest technology, under guidance of a Technical Steering Committee for a) Kyasanur Forest Disease b) Cell Culture Anti Rabies vaccine and vaccines against typhoid, Japanese Encephalitis and other vaccine preventable diseases in collaboration with the Department of Animal Husbandary.*	Self-reliant, efficient and effective vaccine manufacture system will be established in the state.

Sl.No.	Major Recommendations	Outcome expected
5.4.3.4	*Maintenance of cold chain and utilising it for all drugs and vaccines that require cold chain.*	Better coverage and effectiveness of the Immunisation Programme.
5.4.4	**FOOD AND WATER BORNE DISEASES**	
5.4.4.1	*The Health System must establish a functional disease surveillance system and develop epidemiological, microbiological and chemical analysis and expertise and facilities for early outbreak control.*	Early control of food and water borne epidemic out breaks.
5.4.4.2	*The health system must establish routine periodic monitoring of water for coliforms and chlorine content. Each local area health authority must develop its own plan of action to monitor water quality. At any point when coliform is found in supplied water, that information must be immediately made available to the local government, the water supply agency and also to the public (consumers). Health System will also provide technical advice for correcting the deficiencies and to monitor progress.*	Provision of safe, adequate and acceptable drinking water to the public.
5.4.4.3	*The Health Department must review and revise the regulations and legislative measures governing food safety. Regulations must include all food serving facilities including street vending. They must check and prevent adulteration and contamination of foods at various stages of production, processing, storage, transport and distribution..*	Enhanced food safety.
5.4.4.4	*The Health Department should develop guidelines for the health check-up and immunisation of food handlers against typhoid fever and hepatitis A.* *Control measures recommended include, training and certification of food handlers in restaurants, hostels, hotels etc.*	Enhanced food safety.
5.4.5	**HIV / AIDS, REPRODUCTIVE TRACT INFECTIONS & SEXUALLY TRANSMITTED INFECTIONS**	
5.4.5.1	***Prevention:*** *Health education especially targeting adolescents, women's groups etc. -The 'men make a difference' campaign, attempting to make men more responsible in the control of the epidemic. The male and female health workers should promote condom use as an infection preventive measure in addition to their use for spacing of pregnancies.*	Prevention of sexually transmitted diseases.

Sl.No.	Major Recommendations	Outcome expected
5.4.5.2	***STD services**: Laboratory diagnosis and treatment of STI/RTI from PHC upwards. HIV diagnostic facilities in each of the 27 districts to run as Voluntary Testing Centres with counsellors and social workers. Training of Medical Personnel on counseling of the STD / HIV patients as well as their sexual partners.*	Improved diagnostic and treatment facilities
5.4.5.3	***Early diagnosis and treatment of Opportunistic Infections**. Treatment and admission should be possible at all district hospitals. Provision of ethical and effective antiretroviral therapies – antenatal, Post-Exposure-Prophylaxis & for HIV infected. The state/country could use provisions under WTO for indigenous production, which would lower costs.*	Treatment of HIV and apportunistic infections.
5.4.5.4	***A multi-tier system** of networked continuum of care, modeled on the Bangalore experience of NIMHANS, Bowring Hospital, NGO-network based day care & hospice care and home based care, including use of herbal medicine and other systems of healing with back-up support from referral hospitals.*	Continuum of care.
5.4.5.5	***Capacity building** within the Health & Family Welfare Departments including training, Public-Private partnership etc. to effect prevention, treatment and continued management of sexually transmitted diseases should be undertaken.*	Improvement in the management of sexually transmitted diseases.
5.4.6.	**LEPROSY**	
5.4.6.1	*The Department of Health should **maintain the expertise** and skills developed and sustained over the years in the detection and management of leprosy even after integration of leprosy into primary health care.*	Expertise and skills retained.
5.4.6.2	*The Leprosy **incidence must be closely monitored** so that under-diagnosis, if any, due to the integration with the primary health care system, may be identified and rectified without losing ground.*	There is a view that incidence continues. Care can be exercised by monitoring.
5.4.6.3	***Rehabilitation of leprosy cured persons** with disability to be taken up seriously.*	Leprosy cured persons with disabilities rehabilitated.
5.4.7	**RABIES**	
5.4.7.1	*The responsibility of dogs on the streets belongs on the legally correct agency. The health authority should imme-*	Intersectoral collaboration for prevention of rabies.

Sl.No.	Major Recommendations	Outcome expected
	diately call a meeting of the relevant agencies: those who manage roads, veterinarians, health personnel, local administration, Vaccine Institute, SPCA, animal activist lobbies, ministry of environment etc. and prepare a comprehensive action plan, within 6 months, defining responsibilities. The plan of action must be put to action, which should include education of the public on rabies.	
5.4.7.2	*Decision to* ***discontinue the use of animal brain rabies*** *vaccine, and to replace with a cell culture vaccine. Design the transition from animal brain ARV to cell culture ARV. Evolve a method to give cell culture vaccine at no payment to poor people but leave the private sector patients to purchase it. The price of cell culture vaccine may come down drastically, if bulk orders are placed. Explore manufacturing of cell culture vaccine.*	Availability of cell culture vaccine, with much less complications.
5.4.7.3	*Continuing Medical Education for correct management of animal bites to all registered practitioners / hospitals, and other personnel. State Institute of Health & FW to be in charge. Material to be professionally prepared.*	Improved management of animal bites.
	5.4.8 OTHER INFECTIOUS DISEASES	
5.4.8.1	*Active search to be conducted in the erstwhile endemic districts with Guinea worm disease, to ensure its complete elimination, and the result to be reported in the 2000-2001 Annual Report of the Department of H&FW.*	Complete elimination of Guinea worm diseases.
5.4.8.2	*The expanded laboratory in the Public Health System, at the State level, must develop expertise in the microbiology of the following diseases and develop training, reagents and standardisation of laboratory test for the District Laboratories; Leptospirosis, Brucellosis, Anthrax, Plague.*	Control of Leptospirosis, Brucellosis, Anthrax and Plague.
5.4.8.3	*After a disease surveillance system is established, a laboratory based information system must be developed in order to pool and collate laboratory generated information in infectious and parasite diseases. This will give the geographic prevalence of specific infectious diseases so that intervention can be designed and applied.*	Control of infectious diseases.
5.4.8.4	*A mechanism to coordinate public health activities between the Departments of Animal Husbandry and Health and Family Welfare must be created. Such a mechanism*	Co-ordination of Animal Husbandary and Health Departments to prevent infectious diseases.

Sl.No.	Major Recommendations	Outcome expected
	will help in epidemiological investigations, development of laboratory skills, vaccine manufacture and development, health education, and preventive intervention.	
5.4.8.5	*It is recommended that all primary health centres and even sub-centres are provided with simple drugs to treat skin infections.*	All essential drugs are available
5.4.8.6	*Provision of antibiotics at PHCs and referral facilities for other interventions at taluk hospital level. Audiometry at least at district hospital level.*	Impairment of hearing prevented.
5.5	**DISEASE SURVEILLANCE**	
5.5.1	*An epidemiological disease surveillance system to be initiated in two districts in 2001 and then progressively expanded to cover the entire state over a period of two years. The purpose of the system is for public health action.*	Disease Surveillance System in place.
5.5.2	*The State Public Health Institute (PHI) will be adequately staffed and equipped with the State and District public health laboratories reporting to it.*	The State Public Health Institute is fully functional.
5.6	**NON-COMMUNICABLE DISEASES**	
5.6.1.	**DIABETES MELLITUS**	
5.6.1.1	***Epidemiological surveys*** *may be undertaken in rural, and urban areas to understand the "burden" of Diabetes Mellitus and for proper planning for control and prevention of Diabetes Mellitus. The help of specialist association / NGO's may be sought. The survey may be confined to the age group between 20-90 using fasting blood sugar level above126mg/dl as the criterion using the glucometer. (The survey of hypertension, coronary artery disease and stroke may be undertaken along with diabetic survey).*	Better planning for control and prevention of diabetes mellitus.
5.6.1.2	***Laboratory facilities****: It is essential to provide minimum necessary facilities to diagnose Diabetes mellitus even at PHC level. This includes, a colorimeter, glucostrips or Benedict's solution. (The calorimeter may also be used for estimating Blood Urea & Creatinine).*	Improved diagnosis of diabetes mellitus.
5.6.1.3	***Constant supply of essential drugs*** *like insulins and oral hypoglycemic compounds are necessary. The conventional insulin may be used instead of costly ones like purified / Human Insulins except in certain special circumstances.*	Essential drugs and available.

Sl.No.	Major Recommendations	Outcome expected
5.6.1.4	***Continuing Medical Education (CME) & other training programmes**: Doctors / nurses and technicians must be exposed to CME programmes regarding the early detection, treatment and preventive measures. The course may be of 3-5 days duration.*	The capacities of health personnel in the management of diabetes mellitus improved.
5.6.1.5	***Referral System**: Most of the patients can be treated at PHC level itself and occasionally patients need to be transferred to the CHC / Taluka hospital for specialist opinion and treatment. The patients with emergencies like Diabetic Coma and gangrene should be transferred to the higher level of care. Other patients with chronic complications may be referred or specialist's visits may be organised at PHC's on regular basis. Some guidelines may be formed for referral / treatment.*	Patients are managed at appropriate levels.
5.6.1.6	***Health Education**: The health education is promoted with regard to the early symptoms and complications especially foot care and diet; prevention of disease & its complications. There is a need for orientation course for health workers / IEC staff regarding various aspects of Diabetes mellitus with special emphasis on diet, exercise and foot care.*	Better awareness of the disease leading to action.
5.6.1.7	*Develop "**District Diabetes Control Programme**". One Specialist for all non communicable diseases at the district may be designated for supervision, detection, drug supply and health education programme.*	There is a designated Officer and a district programme.
5.6.2.	**CARDIOVASCULAR DISEASES** **CORONARY ARTERY DISEASE (CAD)**	
5.6.2.1	***Epidemiological sample survey** regarding the risk factors may be conducted especially for diabetes mellitus, high blood pressure, positive family history and smoking which will help in prevention strategies. Preventive measures may be initiated now itself based on available data. Health education programmes to be strengthened to reduce risk factors.*	Prevention of coronary artery disease.
5.6.2.2.	***Case detection and emergency management** of ischaemic heart disease, to be done at PHC / general practitioner's level. The person has to be transported to CHC / Taluka Level Hospital for confirmation of diagnosis and further management.*	Management of ischaemic heart disease.

Sl.No.	Major Recommendations	Outcome expected
5.6.2.3	*The **essential drugs** like Nitroglycerine tablets, Pethidine, Morphine, parenteral diuretics, oxygen etc must always be available. Well-equipped Ambulance services to shift the patient to referral centres should be available.*	Improved patient management.
	HYPERTENSION	
5.6.2.4	*There is need for **multiple sample surveys** to be conducted, to have some idea of the "burden" of the disease, for proper planning of our strategy for the management of hypertension. There is need to take co-operation of NGO's and specialist organisations. Estimation of blood pressure must be a part of routine examination by the doctor.*	Better management of persons with hypertension.
5.6.2.5	*Facilities: ensure availability of well maintained standard mercury sphygmomanometer with standard cuff in all centres. For investigations like ECG and chest X-ray the cases may be referred.*	Improved facilities for diagnosis.
5.6.2.6	***Constant supply of antihypertensive** drugs must be maintained. Less expensive drugs with minimum frequency of dosage are preferred which increases the patient's compliance.*	Improved availability of essential drugs.
5.6.2.7	*Health education programmes are very essential for both primary and secondary prevention. Special stress on control of smoking, restriction of salt, saturated fat intake and reduction of weight has to be laid.*	Health promotion, avoiding risk factors.
	RHEUMATIC FEVER / HEART DISEASES	
5.6.2.8	*Rheumatic fever may be detected at PHC level and treated. Benzathine Pencillin should be supplied to PHC's for Rheumatic fever prophylaxis programme. (It is advisable to give penicillin upto 25yrs).*	Detection and management of rheumatic fever at PHC.
5.6.2.9	*Patients with Rheumatic Heart Disease are referred to specialist / tertiary care hospital for special investigations, surgery and other interventions.*	Patient with rheumatic heart disease gets specialist treatment.
	THROMBO ANGITIS OBLITERANS (BERGER'S DISEASE)	
5.6.2.10	*Discourage use of tobacco (a definite measure to prevent disease).*	Prevention of thrombo-angitis obliterans.

Sl.No.	Major Recommendations	Outcome expected
5.6.3	**CHRONIC BRONCHITIS and ASTHMA**	
5.6.3.1	*Every health centre / practitioner must have the drugs and facilities always available to treat asthmatics. Drug supply should include injections of Deriphylline, Aminophylline, Adrenaline, Steroids and tablets of Salbutomol, terbutaline. It is desirable to supply pressurised aerosol nebuliser in every health centre, so that an acute attack may be relieved, even at subcentre levels.*	Availability of essential drugs assured to manage patients with asthma.
5.6.3.2	*Preventive measures and health education may be addressed individually. Lowering environmental / industrial pollution should be taken up as a part of wider health issues. Preventive measures, health education regarding smoking and control of air pollution are important from individual / community angle.*	Reduction in attacks of asthma
5.6.4	**CANCER**	
5.6.4.1	***Primary prevention*** - *Health promotion programmes in schools and colleges to reduce use of tobacco and intensive anti-tobacco campaigns by doctors, nurses, paramedicals, teachers, social worker and anganwadi workers and voluntary organsiations* - *Orientation programmes in the problems of tobacco use for all people's representatives and other decision makers.* *Legislation to reduce tobacco use*	Prevention of use of tobacco
5.6.4.2	***Secondary prevention**: Have cancer detection camps with the help of voluntary organisations to create awareness and detect cancers at early stage and have cancer detection units in hospitals*	Early detection of cancer.
5.6.4.3	***Tertiary prevention**: Have multidisciplinary treatment facilities at Kidwai and other identified centers: surgical, medical, radiation oncology and supportive systems*	Effective treatment of cancer patients.
5.6.4.4	***Palliative care** for terminally ill cancer patients.*	Palliative care
5.6.4.5	*Have a **District Cancer Control Programme**, consisting of a field unit and a clinical team, with staff trained at Kidwai Memorial Institute of Oncology and located at the District Hospital. Extend the programme to all the districts in phased manner.*	Early detection of cancer and management

Sl.No.	Major Recommendations	Outcome expected
5.6.5	**OTHER NON-COMMUNICABLE DISEASES**	
5.6.5.1	**FLUROSIS**	
5.6.5.1.1	*Make available alternate drinking water with less than 1ppm of fluoride to people living in areas where the fluoride content is more than 1ppm.*	Fluoride poisoning controlled.
5.6.5.2	**HANDIGODU DISEASE**	
5.6.5.2.1	*Vacancies at the Handigodu Disease Unit at Sagar Hospital to be filled up and made fully functional along with the mobile unit. Disease surveillance system should be introduced for Handigodu Syndrome.*	All vacancies are filled up resulting in improved quality of care. A special component of the Disease Surveillance System.
5.6.5.2.2	***Genetic counseling** regarding marriage, child bearing, risk estimates on the basis of pedigree analysis.*	Prevention of the disease.
5.6.5.2.3	*Early diagnosis (By X-ray), treatment, surgical correction and rehabilitation should be provided to all the affected including those in Chikkamagalur district. Patients with Handigodu Disease should be provided with supplementary calcium in dietary and tablet forms.*	Handigodu patients rehabilitated.
5.7	**ORAL HEALTH**	
5.7.1	*Have oral (dental) health promotion activity at every level of health care and as part of the school health programme.*	Improved oral (dental) health
5.7.2	*All **vacancies of dental health officers** to be filled up by suitably qualified persons. All dental clinics should have the necessary equipments and facilities, which should be maintained in good working condition*	Improved facilities at all dental clinics.
5.7.3	*A **designated post of Deputy Director** to be in charge of Dental Health Services and Dental Education, at the Directorate.*	A designated officer at the Directorate made responsible for oral (dental) health.
5.8	***OCCUPATIONAL HEALTH***	
5.8.1	*The use of pesticides must be reduced to the minimum. Only such insecticides as are found to be not harmful within the recommended dosage should be allowed to be manufactured / imported and used. The cumulative effects should be considered. Monitor continuously the effect of the use of pesticide. If found harmful, withdraw it.*	Harmful insecticides eliminated.

Sl.No.	Major Recommendations	Outcome expected
5.8.2	*Ensure pre-employment and periodical health check-ups of all workers.*	Detect occupational health problems at the earliest.
5.9	**CONTROL OF BLINDNESS**	
5.9.1	***Strengthen the State Ophthalmic Cell**, filling up vacancies, and long term continuity of Joint Director.*	Improved activities of the State Ophthalmic Cell.
5.9.2	*Ensure accountability of the ophthalmologist and ophthalmic units.*	Improved performance.
5.9.3	*Integrate school eye screening with the health check-up of school children*	Improved eye check up.
5.9.4	*All Medical Colleges Eye Departments should take up in-reach base hospital programme*	Better blindness control.
5.9.5	*All taluk hospitals (upgraded by KHSDP) should be made base hospitals for conventional cataract surgery and be allotted a fixed geographical area.* *All districts should have at least two Government base hospitals where IOL surgery is available.* *The District Medical Officer should co-ordinate and depute the available surgical manpower to fixed surgical centers on the operation days in the districts.*	Increased number of cataract surgeries.
5.9.6	***Screening in the community** by the health worker to identify and refer persons at risk of developing glaucoma to ophthalmologist for evaluation and management.*	Improved early management of glaucoma.
5.9.7	*Prevention, early diagnosis and intervention in persons liable for corneal opacities causing blindness.*	Better management of corneal opacities.
5.9.8	***Establish speciality clinics**: glaucoma, vitreo-retinal and corneal grafting centre, one each for each region.*	Improved management of eye problems.
	5.10 TOBACCO CONTROL	
5.10.1	**BAN OF TOBACCO CONSUMPTION:** *Complete ban on smoking in public places such as:* *a. Hospitals and all other health care facilities and Educational Institutions (Schools, Colleges, University).* *b. Transport facilities, including Air travel (domestic), Buses and Trains: Separation of smoking and non-smoking compartments.* *c. Waiting areas: Airports and Hotel lobbies (Segregation) of smoking areas from non-smoking areas.* *d. Theaters / Cinemas and Restaurants*	Smoking is reduced including passive smoking

Sl.No.	Major Recommendations	Outcome expected
	e. Sports arenas. *f. Museums, libraries and closed areas of Tourist Interest:* *g. Work site (segregated area for smoker at recreational / eating facilities).*	
5.10.2	**BAN ON TOBACCO SALE:** *Ban on sale of tobacco and tobacco containing products to minors (below 18 years of age) and in the immediate vicinity of educational institutions*	Tobacco use by children and adolescents is reduced.
5.10.3	**BAN ON TOBACCO ADVERTISMENT / PROMOTION:** *All hoarding / poster advertisement to be banned, including in / on all transport facilities.* *Radio and Television ban on tobacco advertising should be continued.* *Advertisement in Cinema halls / Videocassettes / audio and in print media.* *Point of sale advertising should be prohibited. Warning symbols and health warning should be prominently displayed at the point of sale.* *Ban on all forms of sports and arts sponsorships or linkage with sports goods / accessories should be effected. This ban should apply to all tobacco products and to other products with the same brand name. Indirect sponsorship through setting up of trusts, etc., should be banned* *All promotional activities for any tobacco product such as free distribution, mailings, discount offer etc., should be banned*	Demand for tobacco products is reduced.
5.10.4	**STATUTORY WARNING ON PACKAGING / NICOTINE AND TAR CONTENT:** *Notification of nicotine and tar content on all packages of the cigarettes and beedies and all products with tobacco should be made compulsory. Size of the statutory warning should be as large (in letter size) as the brand name and in the local (regional) language*	Demand for and use of tobacco is reduced.
5.10.5	*Nicotine and tar content of cigarettes should be progressively reduced, in a specified time frame.*	Adverse effects reduced.
5.10.6	**TAXATION:** *Taxes on all tobacco products should be increased. A specified percentage of the tax revenue from tobacco should be set aside for health education on tobacco related diseases.*	Demand for and use of tobacco is reduced.

.No.	Major Recommendations	Outcome expected
10.7	**INCENTIVES:** *Farmers who change over from tobacco to alternate crops should be provided monetary and other incentives for three years.*	Availability of tobacco is reduced.
10.8	*Promote diversification of tobacco industry into other industries such as information technology.*	Availability of tobacco products reduced.
10.9	**ENVIRONMENTAL LEGISLATION:**	
	Environmental legislation to provide for a targeted compulsory compensatory reforestation programme by tobacco producers and industry to make up for a tobacco curing related deforestation. A specific tax may be levied for this purpose.	Deforestation is reduced.
10.10	**MISCELLANEOUS:***Improve working condition of beedi workers. Industry must provide for medical care of the workers. Have alternate employment for beedi workers and labourers now working in tobacco growing, curing, etc.,*	Improvement of health of the workers.
0.11	*Investment of public sector funds in the tobacco industry must be stopped.*	No encouragement to tobacco industry.
1	**ALCOHOL AND HEALTH**	
1.1	***Training of all Medical Officers*** *and especially at the Primary Health Care level on screening the patient for alcohol abuse problem with a simple questionairre, early detection and interventions for alcohol-related health problems. The training should include sensitization regarding association of alcohol use with violence in the family, and association with STDs & HIV/AIDS.*	Medical officers are skilled in the detection and interventions for alcohol related problems.
1.2	***Referral centres*** *for treatment of alcoholism should be identified or set up at district levels. The treatment programme should include detoxification, treatment of withdrawal symptoms, psychological therapy and long-term relapse-prevention programmes to ensure abstinence*	Alcoholism is managed effectively.
1.3	*Referral to local self-help groups like Alcoholics Anonymous should be encouraged as part of the relapse prevention programmes for treatment of alcoholism.*	Alcoholism is reduced.
1.4	*The model of "**camp-approach**" for treatment of alcoholics which is being successfully implemented by TTK Hospital, Chennai, in some centres in Tamil Nadu could be tried in Karnataka. Involve the local community in the relapse-prevention programme.*	Relapse of alcoholism is prevented.

Sl.No.	Major Recommendations	Outcome expected
5.11.5	*The departments of Excise (Finance), Health, Education, Social Welfare and Police should work together to implement and* ***enforce the existing regulations*** *and measures applying to production, sales, retail, taxation and advertising of alcohol.*	Better enforcement of regulations controlling alcohol.
5.11.6	*A* ***differential Tax structure*** *with a higher taxation on liquors than on beer or wine will help in discouraging the drinking of beverages with higher alcohol content.*	Discouraging drinking of beverages with higher alcohol content.
5.11.7	*A* ***general awareness*** *about "drinking and driving" should be undertaken by the Transport department. This should specify the type and amount of drink over which the person should not drive, explained in lay terms and not as percentage of alcohol. The laws against drinking and driving should be strictly implemented and exemplary punishment must be awarded to offenders.*	Alcohol related road accidents are reduced.
5.11.8	*Measures to* ***prevent production and sale of illicit liquor*** *should be enforced.*	Harmful effects of illicit liquor are avoided.
5.11.9	***Health education programmes*** *for children and adolescents should include substance (including alcohol) abuse as well as Life Skills Education.*	Children and adolescents learn to avoid alcohol.
5.11.10	***Community level interventions*** *by Government and by NGOs should include community awareness, Health Education, social support for battered women and children following alcohol consumption and vocational rehabilitation for reformed alcoholics.*	Domestic violence following drinking is reduced.
5.11.11	*Advertising agencies and media should be encouraged to self-regulate and avoid even covert messages.*	Demand for alcohol is reduced.
5.12	**HEALTH ASPECTS OF DISASTER MANAGEMENT**	
5.12	*The Government of Karnataka should commission a competent group of experts, administrators and policy makers including those in the field of health, to prepare a multi hazard plan for all districts in the state of Karnataka. This Plan should be completed before the end of the year 2001.*	Disaster management is a large issue which must be tackled with intersectoral cooperation.

Sl.No.	Major Recommendations	Outcome expected
	5. MENTAL HEALTH & NEUROSCIENCES	
6.1	**MENTAL HEALTH**	
6.1.1	*Train the medical officers and others at the Primary Health Centres to recognize mental health problems early, manage them effectively or refer them.*	Mental health problems are recognised early and managed effectively.
6.1.2	*Have **District Mental Health programmes** in all districts on the model of Bellary District Programme. All district hospitals to have mental health units with qualified psychiatrists and other trained staff and facilities for outpatient and inpatient care of the mentally ill persons.*	Every district has an effective mental health programme.
6.1.3	*Ensure **availability of essential drugs** for the management of mental disorders. Have counseling centers with qualified and trained personnel.*	Effective management of mental disorders.
6.1.4	*All medical colleges should have qualified psychiatrists and facilities for teaching medical students and for outpatient and inpatient care of mentally ill persons.*	Training of medical students and service is improved.
6.1.5	***Upgrade the Dharwad Mental Hospital**, converting it to a centre of active treatment in a humane way.*	The only state institute has upgraded facilities and patient - centered care.
6.1.6	*Encourage community based rehabilitation of persons with mental disorders, who have recovered from acute illness. Encourage community based rehabilitation of persons with mental retardation, integrating them into the society.*	Community based rehabilitation of persons with mental retardation or chronic mental disorder.
6.2	**NEUROLOGICAL DISORDERS**	
6.2.1	**EPILEPSY**	
6.2.1.1	***Epilepsy Education**: It is a key area that needs immediate attention. These programmes should aim at relieving stigma, and improving the compliance of the patient in taking drugs. It must also highlight DO's and DONT'S and focus on positive outlook on epilepsy. Recognise different types of epilepsy, including hot water epilepsy. Awareness should be created on Hot Water Epilepsy particularly in Chamarajanagar, Mysore and Mandya District.*	Better awareness of the problem and improved compliance with prolonged medication.

Sl.No.	Major Recommendations	Outcome expected
6.2.1.2	*The primary care physicians (both PHC doctor and private practitioner) and auxiliary staff have to be trained by a short term course, regarding diagnosis, treatment, epilepsy education, record keeping and monitoring. There must be a continuous supply of anti-epileptic drugs.*	Improved early diagnosis and treatment.
6.2.1.3	*Establish and strengthen epilepsy services at district hospitals through out-patients clinics with adequate supply of drugs. The district medical officers, physicians and paediatricians may be trained by a short course as it is done at NIMHANS under epilepsy control programme. Have a* ***District Epilepsy Control Programme*** *for planning, implementing, supervising and evaluating, epilepsy services. The programme officer may be incharge of all non-communicable disease.*	Improved management of epilepsy at the districts.
6.2.2	**STROKE**	
6.2.2.1	*Control of hypertension, discouraging smoking, reducing intake of saturated fats, and control of obesity are important measures to be instituted at all levels of health care. Antiplatelet drugs like aspirin 100-325mg are prescribed, to prevent further attacks. It may be used as primary prevention in a person who has a strong family history and risk factors.*	Stroke is prevented.
6.2.2.2	*Majority of stroke may be managed at PHC level with well-trained staff and certain specific cases to referred secondary / tertiary level as an emergency*	Effective management of patients with stroke.
6.2.2.3	***Training programmes*** *for the management of all causes of neurological disorders to be instituted at NIMHANS for primary care physicians, both private and public. The training should be practical and should include physiotherapy.*	Improved training to deal with 'stroke'.
6.2.3.	**NEUROLOGY AND NEUROSURGERY SERVICES IN GOVERNMENT MEDICAL COLLEGES**	
6.2.3	*The Government of Karnataka must initiate immediate and energetic steps to* ***establish Neurology and Neurosurgery services*** *in all the four government medical colleges.*	Improved services in neurology and neurosurgery available at the Medical Colleges.

Sl.No.	Major Recommendations	Outcome expected
	Train physicians and general surgeons at taluka and district hospitals to manage neurological disorders and head injuries and refer patients, when necessary to the Medical Colleges / NIMHANS, Bangalore.	
6.2.4.	**HEAD INJURIES AND TRAFFIC ACCIDENTS**	
6.2.4	*The **law regarding compulsory wearing of crash helmet** by riders and pillion riders of two wheelers must be re-introduced to protect them from severe head injury. It is essential to educate the public regarding the road safety measures and benefits of wearing the helmet.*	Riders of two wheelers are better protected from the effects of head injury.
	7. NUTRITION	
7.1	*Supplementary food supply to pregnant mothers be increased, based on the need; this can be assessed based on the gain in weight, after excluding other causes.*	Improved nutrition status of the mother and the unborn child.
7.2	***Breast feeding** to commence soon after delivery, to use the highly beneficial colostrums. Exclusive breastfeeding during the first 6 months. Breastfeeding to continue for 18-24 months (Method: education of the mother).*	Breast milk is wholesome food and nourishes the child.
7.3	***Semisolid weaning (supplementary) food**, adequate in quantity and quality, be given to the infant under the ICDS scheme. In the case of the poor, weaning food be supplied free to the infants above 6 months (Department of Health Family Welfare services with the help of the departments of Women and Child Welfare and Food Supplies).*	Supplementary food ensures adequate nutrition.
7.4	*Growth monitoring to detect growth faltering, based on weights taken by anganwadi workers, with well-calibrated balances; follow-up action by the medical officers of PHC. If malnutrition is severe, admission and management.*	Early detection of under nutrition and intervention.
7.5	***Free mid-day meals** (nutritious) to poor school children. (Department of Education).*	Improved nutrition and performance at school.
7.6	*PDS must be strengthened. More foods like ragi, other*	Improved nutrition of the poor.

Sl.No.	Major Recommendations	Outcome expected
	pulses and oil to be supplied to the green card holders (Food and Civil Supplies).	
7.7	***Ensure supply of iron-folic acid** to adolescent girls and pregnant mothers. Ensure vitamin A prophylaxis. Calcium tablets to be supplied if indicated, to lactating and older women.Iodised salt in goiter prevalent districts.*	Micronutrients are made available.
7.7	*Nutrition and Health Education (Health and Family Welfare Services, Medical and Nursing Colleges and schools, University departments of Nutrition and Home Sciences); Nutrition education of the public.*	Improved awareness leading to action to reduce malnutrition.
7.9	*Prevent infection. If infection occurs, treat promptly. Improve access to health care of infants, children and pregnant mothers to PHCs and CHCs with the help of Paediatricians and Obstetricians and Gynaecologists. **Safe drinking water and improved sanitation** to prevent diarrheas and worm infestation. Periodical (once in a year) deworming.*	The additve effect of infection on undernutrition is prevented; so also the effect of other diseases.
7.10	*The District Nutrition Officer will co-ordinate the nutrition programmes in the district.*	A designated officer is given the responsibility to monitor and take corrective action.
7.11	*Encourage use of green leafy vegetables. Every house to have a kitchen garden. The Department of Horticulture to help with supply of seeds, seedlings, etc and promote the development of kitchen (nutrition) garden with drumstick plants, green leafy vegetables, etc. Every PHC to consider possibility of developing a demonstration plot.*	Improved nutrition at low cost.
7.12	*Constitute an interministerial co-ordination committee (Health, food and civil supplies, agriculture, education, rural development and social welfare) to tackle the problem of malnutrition.*	Improvement in nutrition requires multi sectoral coordination.
	8. WOMEN AND CHILD HEALTH	
8.1	**WOMEN'S HEALTH**	
	While general recommendations regarding Nutrition, STD & HIV/AIDS; Cancer control among women etc, are incorporated in the chapters on these topics, specific issues are emphasized here.	

Sl.No.	Major Recommendations	Outcome expected
8.1.1	*All Health -care personnel should be sensitized on issues relating to gender inequalities. The curriculum for Medical Education and for training programs for health care personnel should include gender perspectives.*	All health care personnel become aware of and sensitive to gender issues.
8.1.2	***Gender dis-aggregated data and gender sensitive indicators** to evaluate gender equity should be integrated in all plans & programs. Examples of gender disaggregated data would include birth and death details, actual consumption of the food and micro-nutrients supplied to pregnant women through the RCH / ICDS programmes; admissions & attendance at schools, hospital in-patient & out-patient records, immunization details, salary patterns for the same jobs and so on.*	Disaggregated data on various issues affecting the health of the people become available for suitable action.
8.1.3	*Violence against women and girls at societal and household levels to be eliminated through strengthening of institutional capacity (especially Health, Police and Judicial Sectors); involvement of women, and review of certain existing legal provisions*	Action to be taken to eliminate violence against women.
8.1.4	***Health Sector:*** ***Privacy** is essential when interviewing clients about domestic violence and this should be ensured. Health personnel should be trained adequately and sensitively to recognize and treat signs of domestic violence, sexual abuse & violence associated with alcohol abuse; give legal advice and counseling. The hospitals should be made women friendly.*	Violence and sexual abuse are recognized and appropriate advice is given.
8.1.5	***Long term psychological support** for sexually abused children of a trained counseller / psychologist / psychosocial worker / psychiatrist should be identified within the Health system.*	Services of a counselor/ psychologist/ psychosocial worker is made available to sexually abused children.
8.1.6	***Female foeticide & infanticide:*** *Actively look for female foeticide & infanticide.. Gender ratio at birth and other indicators to show trends, underlying causes should be used for community-level control programmes. The services of religious leaders can be used to strengthen the programme against foeticide and infanticide. IMA & other professional bodies should be encouraged to sensitize doctors to the legal &ethical aspects; self-regulate and socially boycott known offenders.*	Female foeticide and infanticide are reduced and finally eliminated.

Sl.No.	Major Recommendations	Outcome expected
8.1.7	*The **Prenatal Diagnostic Techniques Act,1994**, should be enforced strictly.*	Female foeticide is reduced.
8.2	**CHILD HEALTH**	
8.2.1	*Have an additional health worker appointed by the Gram Sabha and trained to receive and resuscitate the newly born along with other duties as an experimental measure in the 7 northern districts found to have lower health status and extended, if found useful.*	Neonatal deaths are reduced.
8.2.2	*Develop Indira Gandhi Institute of Child Health as the apex body for training, service and research in child health. Tackle the major childhood problems of diarrhoea (leading to dehydration) and acute respiratory infections.*	Reduced child mortality and improved referrel care
8.2.3	*Health education for children and adolescents should be the responsibility of the Health as well as Education department. This should be integrated into the formal school system and should include nutrition; sanitation; reproductive health, RTI/STI; HIV/AIDS; substance abuse, values & life skills and gender issues; Alternate mechanisms to reach school dropouts should be identified.*	School health education for children and adolescents brings about responsible behaviour.
8.3	**REPRODUCTIVE & CHILD HEALTH PROGRAMME**	
8.3.1	***Quality of Services*** *The general quality of RCH services should be improved; a Quality Assurance programme should be developed and implemented. Changes in the procedure, equipment specifications, new techniques etc. should go through a specified evaluation process before being accepted for implementation. The patient's comfort and dignity are of first consideration. So the tilted laproscopy tables & other such inconsiderate methodology should not be used.*	Quality and patients convenience and satisfaction are assured
8.3.2	*The attitude of doctors and other staff should be positive and helpful. This can be ensured through periodic internal audits, patient satisfaction studies and accreditation system with an external audit. Periodic auditing of maternal and infant deaths should be implemented to institute preventive strategies.*	Periodic audits are in place to ensure quality care.
8.3.3	*Availability of safe abortion (MTP) services for all women should be ensured. Sterilizations and MTPs should be carried out only at first referral units (Fixed-Day strategy) and not at camps.*	Safe MTPs are assured.

Sl.No.	Major Recommendations	Outcome expected
3.3.4	***Infrastructure-Staff:*** *The system of* ***deliveries by Dais*** *should be supported, with enhanced training. Initial as well as periodic reorientation training for all birth attendants to ensure quality should be implemented. There should be periodic evaluation and up-gradation of the training courses.*	Improved performance by the trained birth attendant, resulting in safe delivery.
3.3.5	*To solve the problem of safety and timely attendance of ANMs: as far as possible, ANMs should be posted in their home villages; given loan facility to buy a two wheeler. Their workload needs to be rationalized- less paper work and better use of their expertise and talent*	ANMs have greater mobility and are able to carry out their functions more effectively.
3.3.6	*Ensuring* ***availability of trained staff:*** *Government may consider approved, training courses to provide services in the absence of a Medical Office:, Nurse-Obstetrician Practitioner at the PHC level and Short-term (6m to 1yr) training in anaesthesia for Medical Officers at the CHC level.* *The details of the course, feasibility etc. should be worked out by an expert team.*	In the absence of Lady Medical Officer at PHC, have a nurse-obstetrician trained anaesthetist helps in performing surgical, obstetric and gynaecological operations.
3.3.7	***Disposable delivery kits*** *with good quality cost effective components - with the expectant mothers.*	Improved delivery
3.3.8	***Subsidised menstrual cloth /pads*** *may be supplied to the poor, to promote personal hygiene and should be supported with awareness programmes to ensure correct usage.*	Improved menstrual hygiene.
.3.9	*Male Health Workers should be given adequate training and skills to tackle gender issues and to ensure male participation through individual counseling as well as community education programmes.*	Male participation improves in the programme.
	9. POPULATION STABILIZATION	
.1	*The unmet needs for* ***family planning services*** *should be met, with options of choice and assured quality;*	The needs for family planning services are met.
.2	*Information, education and communication activities should be enhanced to convey messages of the advantages*	IEC programme in place.

Sl.No.	Major Recommendations	Outcome expected
	of postponing the second child, of a two child norm, and of the health and familial advantages of spacing births and of raising age at marriage.	
9.3	*There has to be regular and effective follow up of acceptors after they adopt any of the family planning methods to ensure that complications, if any, are attended to expeditiously. Such follow up would also encourage the increasing acceptance of family planning*	Regular follow-up reduces complications; if complications occur, they are attended to immediately.
9.4	*There should be* ***no element of compulsion*** *or pressure, particularly through camps or "pulse approach". The services should be such that their quality and availability, with regularity and at all times, with choice encourages voluntary adoption of family planning;* (CNA methodology)	Voluntarism and quality improve acceptance.
9.5	*New family planning technology should be adopted only after careful consideration of the ethical aspects of use of such technology, safety issues and cost effectiveness.*	Ethics, safety and cost-effectiveness considered before adopting new technologies.
9.6	*Ensure legal requirement of* ***registration of all marriages****. This would enable the stricter application of the law relating to restriction of age at marriage and assist in organizing out-reach services;*	All marriages are registered.
9.7	*The community, particularly women's groups, should be closely associated, in consultative and operational terms, with family planning programmes to reflect the perceptions and needs of the local community*	Community needs are met.
9.8	*The* ***Population Policy*** *for the State as part of Integrated Health Policy should be drafted. The draft policy would have to be widely publicized for public awareness and response, before it is finalized;*	A State Population Policy as part of the Health Policy becomes available.
9.9	*Districts may be prioritized on the basis of evaluation of the current status of the family planning services available and related social criteria, for enhancing the scale of the programme;*	Districts are prioritized to provide family planning services.
9.10	*For ensuring inter-sectoral coordination and monitoring of the programmes relating to family planning and re-*	A Commission on Social Development and Population is estab-

Sl.No.	Major Recommendations	Outcome expected
	lated sectors, a Committee on Social Development and Population Issues may be established at the official level, while at the Cabinet level a Commission on Social Development and Population may be established.	lished at Cabinet level and a Committee at official level.
	10. FOCUS ON SPECIAL GROUPS	
10.1	**PERSONS WITH DISABILITY**	
10.1.1	*Establish the role of the Health department in Disability Prevention, Early detection, Intervention, corrective surgery and physiotherapy. Sensitise health-care workers on identification, classification, records of progress and evaluation, referral and home-based stimulation training. Staff from Leprosy control programs may be trained first.*	The staff of the Department of Health are sensitive to the issues in disability.
10.1.2	*Utilise Media to create **awareness and training** of parents and other caregivers on specific disabilities.*	Awareness is created among all caregivers
10.1.3	*Shift from institutional approach to a Community Based Rehabilitation-home-(parent) based approach; and from single to a multi-disability approach.*	Community Based approach is adopted.
10.1.4	***Networking initiatives** – Get all people, Government as well as NGOs, from all sectors to meet at a common platform and plan out strategies.*	All people are involved in the programme for rehabilitation.
10.1.5	*Make provision for the manufacture, distribution and repair and maintenance of aids and appliances. Have an orthotic and prosthetic centre at every district hospital (as in Tamil Nadu).*	Aids and appliances are available as required.
10.1.6	*Develop and implement a **policy of inclusive education.** Train teachers for early detection and management of learning difficulties. Include evaluation and management of speech and hearing and other impairments in school health programmes*	Inclusive education is available.
10.1.7	*Ensure access to all health care institutions and other buildings, transport, water supply, sanitation etc., by incorporating necessary provisions in the statutes, rules, etc.*	Improved access to all buildings

Sl.No.	Major Recommendations	Outcome expected
10.1.8	*Implement the provisions of the existing legislation, including* ***Persons with Disabilities Act, 1995*** *with respect to protection of the rights of persons with disabilities. Ensure equal opportunities in employment and training for persons with disabilities, by enforcing current legislation; enhance the provision for training and employment*	Provisions of the Persons with Disabilities Act are applied, ensuring equal opportunities.
10.2	**HEALTH OF THE TRIBAL PEOPLE**	
10.2.1	*A* ***rapid survey*** *of the health status of the tribals should be carried out. Region specific and tribe specific health plans should be made.*	Health status of the tribal people is known.
10.2.2	*The* ***norms for Primary Health Centres*** *and Subcentres in tribal areas should be based on geographical and population basis and they should be flexible.The mobile units should be made functional.*	Improved primary health care services.
10.2.3	*Tribal girls should be selected and trained as* ***tribal ANMs*** *and they should be posted in tribal subcentres. They should also be trained in traditional medicine and health practices.*	Improved health care.
10.2.4	***Traditional healing systems*** *must be encouraged and documented in tribal areas and there should be integration of Allopathic medicine with the Traditional systems. Promote herbal gardens in tribal areas.*	Preservation of traditional healing systems and use for the benefit of the people.
10.2.5	*Genetic diseases like* ***Sickle Cell Anaemia,*** *G 6 PD Deficiency, which are specific to tribals should be given special importance with adequate funds and expertise, for their treatment, research and rehabilitation. Secondary and tertiary care, transport facilities for emergency services and obstetric care are essential. Community financing for emergency transport and referrals Health education, PRA exercises and micro planning, Convergent community action, training in communication skills and mobilisation of local health resources.*	Improved health of the tribal people.
10.2.6	***Ensure food security*** *and encourage growing of nutritionally rich food crops. Public Distribution System should distribute cereals like ragi, bajra and pulses instead of polished rice and sugar. Promote kitchen gardens.*	Better nutrition.

Sl.No.	Major Recommendations	Outcome expected
10.2.7	*A HMIS of the health infrastructure, human resources, vital statistics and other health indicators specially for the tribals is mandatory and should be an on-going process.*	Health Management is improved.
10.2.8	*There should be increased collaboration between the government and the NGOs in tribal areas. The voluntary agencies must be involved in the development activities undertaken by the government.*	Collaboration between Government and Voluntary Organisations for improved health of the tribal people.
10.3.	**THE ELDERLY**	
10.3.1	*A policy for the elderly should be formulated, with particular safeguards for women. The administrative Department responsible for implementation of this policy should be designated. The management of both public and private institutions would need to be sensitized to the special needs of the elderly. Single point counters to avoid multiple trips to various counters in an institution, elimination of long waits and personal interaction.*	A policy for the elderly is available.
10.3.2	*The scale of user fees for health services, if charged, should be reduced in the case of the elderly patients, so as to lessen the burden on the household in availing of medical assistance for the elderly*	The burden on the family because of medical care of the elderly is reduced.
10.3.3	***Geriatric care facilities** should be provided at the secondary and tertiary care levels. In addition, private health institutions should be encouraged to provide such facilities, and a per-patient payment system by Government could be considered.*	Specialised care of the elderly is available.
10.3.4	*For sensitization to the health issues of the elderly and training in providing health services to this group, (a) in-house training in geriatric care should be instituted within the Department, (b) the associations of private institutions could be requested to conduct similar courses, and (c) the content of medical, nursing and paramedical courses to be reviewed so as to train them in geriatric issues.*	Improved care of the elderly.
10.3.5	***Health insurance schemes** for the elderly need to be*	Health Insurance of the elderly in

Sl.No.	Major Recommendations	Outcome expected
	12. HUMAN RESOURCE DEVELOPMENT FOR HEALTH	
2.1	**EDUCATION:**	
12.1.1	*The issuing of **Essentiality Certificates** by the Government and affiliation by the University for new Medical, Dental, Nursing, Pharmacy and Physiotherapy Colleges should be stopped for the next two years, the exception being Colleges in underserved districts of Karnataka. This is to ensure quality of education, with adequate teaching staff and other facilities.* *Extend the moratorium on new Ayurvedic, Unani and Homeopathy Colleges for two more years.* *Fill up all vacancies of teaching staff by suitably qualified persons*	Improved quality of education of health professionals.
12.1.2	*Take up urgently the **repairs** of the building of the colleges, hospitals, hostels, equipments and vehicles of the Government teaching institutions. All equipments must be maintained in good working condition.*	Better facilities for the education of health professionals.//
12.1.3	*Improve the emergency and casualty services. There should be available round the clock diagnostic (x-ray and laboratory) services.*	Improved emergency care
12.1.4	***Medical Colleges should take up 3 PHCs** for training and service. Dental and Nursing Colleges should take up 1-3 PHCs for the same purpose.*	Improved training of students and better service to the people.
12.1.5	***Extra vigilance** is necessary at the University examinations. Corrupt examiners should be debarred from examinerships.*	Corruption is eliminated.
12.1.6	*Monitoring and evaluation (performance appraisal) of teaching and other staff in the health professional colleges and affiliated institutions should be carried out once a year; the performance should be taken into consideration for promotion and other benefits.*	Performance is monitored and action taken.
12.1.7	*Appropriate training and re-training of Heads of Depts, Resident Medical Officers, Medical Superintendents, Principals and Directors in management, (personnel, finan-*	The hospital administration is improved with better utilisation of facilities.

Sl.No.	Major Recommendations	Outcome expected
	cial, materials and time) should be taken up on priority basis. *The possibility of appointing qualified and trained hospital administrators in teaching hospitals to be considered.*	
12.1.8	*Every professional college should have an education unit to improve the teaching capability of teachers. RGUHS should organize teacher-training programmes. Make use of the facilities at the National Teacher Training Institute at JIPMER, Pondicherry.*	Teachers are better trained; quality of education improves.
12.1.9	*The possibility of bringing the non-teaching staff in Medical College Hospitals under the control of Department of Medical Education may be studied and action taken to implement the decision.* *The Officers in the Department of Medical Education should have sufficient powers to take suitable disciplinary action even on staff who are on deputation from the health department. An administrative manual setting out the powers and duties may be brought out.*	The Officers of the department of Medical Education have sufficient administrative and disciplinary control over the staff seconded to the department.
12.2	**TRAINING**	
12.2.1	*Have a detailed survey of the need for training of paramedics and take appropriate action. Review the job oriented paramedical courses.*	There is co-ordination between the needs and the availability of trained personnel.
12.2.2	*Auxiliary nurse midwives training to be taken up seriously. Whether there is need for extension of period of training to 24 months (from 18 months) must be examined.*	Auxiliary nurse midwifes are key personnel in health and they are trained well.
12.2.3	*Use developments in* ***Information technology*** *for continuing education of all health and allied professionals and paramedical personnel.*	Improved training
12.2.4	***The State Institute of Health and Family Welfare*** *should be upgraded to become the apex training institute, making it an institute of excellence.* - *The State Institute will be an autonomous body, with adequate funds for its activities and maintenance allocated from the State Health and Family Welfare Department Budget directly.*	The State Institute becomes the nodal institute for all training and has upgraded facilities.

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	- *The post of Director of the Institute will be selection post. The tenure will be 5 years. The Director will be medically qualified and will have training and experience in education technology and training of trainers. It would be preferable to have persons with some experience of having worked in the Department of Health and Family Welfare Service.* - *The Institute will have full complement of training, research, administrative and supportive staff with appropriate qualifications.* - *Considering the importance of social sciences and communication skills, the Institute will have either full-time / part-time staff for these departments or engage the services of experts as and when required for the training sessions.* - *The Institute will have all the necessary equipment and facilities including teaching / learning space and identified field practice areas.* - *The Institute will have an up-to-date digital library and documentation centre.* *The State Institute will conduct induction and orientation programems for medical officers and other staff and arrange for continuing education for all the staff of the Department of Health and Family Welfare Services and the Department of Indian Systems of Medicine and Homeopathy.*	
12.2.5	***The Regional Health and Family Welfare Training Centre** will be administratively under the State Institute.* - *The regional centers will plan and execute the training programmes based on the needs of the region; these will be supervised and co-ordinated by the State Institute.* - *The Regional Centres should have adequate staff with requisite qualifications, competence and suitability, as also all necessary equipment and facilities.*	The Regional Centres are able to meet the specific needs of the region.
12.2.6	*All Districts will have their own **District Training Centres** to meet the training needs of the district.* - *The District Centres would be under the State Institute administratively* - *The State Institute will plan (along with the District*	The District Centres meet the training needs of the district.

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	Centre), supervise and co-ordinate the training programmes. - *The District Centres will oversee the functioning of the ANM training centers.* - *Adequate staff with necessary qualifications and competence and all necessary equipment and facilities will be provided to the District Centres.*	
12.2.7	*The State Institute will, along with the Strategic Planning Cell of the Directorate of Health and Family Welfare Services, identify the training needs and draw up a master plan for the training of staff at all levels. The training should be in the State mostly. Fellowships / scholarships offered by WHO, Commonwealth and other similar organizations must be availed of. The State Institute and the Planning and Monitoring Division should work together to get the relevant information and have the staff deputed according to the needs of the State and the suitability of the staff member.*	The needs of the State for training are planned and offers for training utilised.
12.2.8	*The State Institute must plan and conduct courses in Public Health:* - *short term orientation courses (2 weeks?) for all medical officers and selected other staff;* - *longer certificate courses (6 months?) for all medical staff in the public health cadres, for the period of transition till sufficient number of persons with DPH or higher qualification are available.* *DPH and higher courses, in collaboration with the Rajiv Gandhi University of Health Sciences, to be started in 3 years.*	Public Health regains its importance in improving the health of the people.
	13. RESEARCH IN HEALTH	
13.1	*Develop **Vision, Mission and Strategy** Statement on research at the primary health care level as also at the secondary and tertiary levels and in public health.*	The process helps the State to plan the research activities.
13.2	*Study the status of research projects (completed and ongoing) managed by the Department of Health and Family Welfare, Medical Education and Indian Systems of Medicine and Homeopathy.*	The study helps to improve the quality of research.

Sl.No.	Major Recommendations	Outcome expected
13.3	*Set up a **Research Board** and a think tank to identify the problems. Invite experts to brainstorm, allocate funds and resources from Government (state and central), Universities, Indian Council of Medical Research, Department of Science and Technology (ICMR, DST) and Pharmaceutical Industries.*	Improved quality of research and adequate funds.
13.4	*Create infrastructure for digital library, information and documentation center. Set up access to the Internet and databases. Make available leading research journals and publications.*	Services of information are increased.
	14. HEALTH SYSTEMS MANAGEMENT	
14.1	**ADMINISTRATION**	
14.1.1	***Structure of Health Services:*** *The emphasis on public health should be revived and its essentiality recognized; two separate cadres may be constituted relating to Public Health and Medical (clinical) based on integrated and common functions.*	Public Health gets its due importance.
14.1.2	*The **Directorate of Health Services** would be in charge of a Commissioner / Director General of Health Services. This post would be filled by a senior IAS Officer of the State Cadre or through contract appointment of an eminent professional from within the department or outside it.*	More efficient and effective functioning.
14.1.3	*The levels of health personnel up to the district level should constitute district cadres, selection to State cadres being made from these cadres on the basis of merit cum seniority. Appropriate transitory mechanisms for exercise of options by the present staff.* *A suitable recruitment mechanism should be established for appointment of doctors and others at the basic level: either a District Recruitment Committee or a State level Local Services Recruitment Board, depending on the level / grades of staff to be recruited;*	District and State cadres come into effect.
14.1.4	*Recruitment doctors would be at the level of the PHC, assignment to the Public Health or Medical Cadres being*	Initial recruitment and subsequent career in two streams.

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	made after a certain period and subject to qualifications and training.	
14.1.5	*A **Taluka Health Team** under the Taluka Health Officer may be constituted which includes the Block Health Educators, Senior Health Inspector, the Refractionist and the Senior Lady Health Visitor;*	A Taluk Health Team is created
14.1.6	*The District Health Officer and the District Medical Officer would be designated as the district health chiefs and be made responsible for all concerned activities in the district;*	The District health chiefs are identified.
14.1.7	***General Administrative Issues:*** *The restructuring of the health services would call for amendment of the Cadre and Recruitment Rules and for consideration of the transitory arrangements. A Committee with the Commissioner as Chairman should be set up for this purpose, with a mandate to complete the process in a specified time so that the new structure is in position in a year's time.*	Amendments to C & R rules to enable the re-organisation of the health services.
14.1.8	*The present system of annual appraisal reports needs to be reviewed and made performance specific. Also, a system of medical audit should be instituted for assessing performance of hospitals;*	Improved performance appraisal so that action can be taken to improve performance.
14.1.9	*Private practice by health personnel would be subject to the following conditions:* *a) Hours of duty will be stipulated in all health / medical institutions of the Directorate and prominently displayed for public knowledge. The hours of work would take regional, seasonal and other factors into consideration. All personnel should adhere to these hours and the responsibility to ensure this would be that of the superior officer;* *b) Doctors may be allowed private practice outside these stipulated duty hours and only when not on call or required for emergency service, subject to the remission every month to Government of one-third the basic pay of the staff member who so practices;* *c) The Directorate would identify and notify those posts*	Conditions under which private practice by doctors in government service is permitted are set out

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	where private practice is banned, based on criteria to be evolved. The incumbents of these posts would be paid a monthly "non-practicing allowance" of one-third the basic pay of the post; *d) All doctors in the Directorate, at all levels, would provide an affidavit at such periodic intervals as may be specified affirming whether they are or are not carrying on private practice. This would form part of the service record;* *Those found contravening the affidavit would be subject to disciplinary actions as may be prescribed in the relevant rules. In the long term private practice all government medical officers will be banned paying them reasonable salaries.*	Medical Officers will be available for better service, training and research
14.1.10	*Internal institutional mechanisms for detection of and enquiry in cases of corruption should be set up for expeditious detection and punishment;*	Corruption is reduced significantly
14.1.11	*All externally aided projects would be within the structure of the Department, even if implemented by a distinct Division within the Department, as suggested in the restructuring of the Department;*	The Department owns the projects
14.1.12	*Morale needs to be built up by adoption of transparent procedures with regard to transfers, selection for training or courses, regularization of contract doctors, providing soft loans for transport to PHC doctors and field personnel and the like.*	The morale of the staff is improved
14.1.13	*The orders relating to delegation of powers, both financial and administrative, need review. The Commissioner may carry out such a review.*	Better delegation of powers leading to early and appropriate action.
14.1.14	*All vacancies should be filled expeditiously. Vacancies in a "service" Department result in serious reduction of quality and availabilty of health facilities;* *Budget cuts for health services should not be made since these not only reduce the scale of the services but also result in deterioration of existing ones. Such cuts are counter productive.*	Health services function efficiently and effectively.
14.1.15	*It is necessary to extend the technical authority of the Director, Public Health / Director, Medical over health*	The Department of Health Services provide technical guidance

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	matters in urban areas that are under the control of the municipal authorities. This could be done through the issue of orders under the existing Municipal Acts.	to the local administration
14.1.16	*The existing mechanisms should be used effectively to monitor and interact with the specialty institutions, including the Central ones;*	Improved co-ordination.
14.1.17	*The possibility of contracting out non-clinical services in increasing degree should be explored;*	Improved efficiency.
14.1.18	*The Population Centre may be redesignated as the Centre for Population and Health Studies, and its role expanded. It may be placed under the Principal Secretary.*	The Centre for Population and Health Studies becomes a centre for evaluation and research.
14.1.19	*The system of registration of births and deaths needs to be reviewed to enhance its accuracy, coverage & utility.*	Improved vital statistics
14.2	**PLANNING AND MONITORING**	
14.2.1	*A Planning and Monitoring Division should be organized incorporating the Strategic Planning Cell and vested with the authority to call for information from all other Divisions. This Division should be responsible for strategic planning of activities of the entire health system, including long term planning, coordination with the Zilla Panchayats to ensure that the health plans of the districts, talukas and Gram Panchayats are integrated into the State Health Plan, and assessing budget resources for current and future needs, taking into consideration population, level and norms for services and other relevant parameters, and assessing human resources and all material resources on a continuing basis.* - *The Division would have to include a Reporting and Monitoring Section, a Geographical Information System, a Computer Division and a Perspective Planning Section.* - *All reporting activities with regard to the HMIS should be vested in this Division. The analysis of information and generation of monitoring reports for various levels would be the responsibility of this Division, to enable assessing performance and initiating corrective action;*	A planning and monitoring division comes into function to plan, prioritise, workout budget resources, monitor and evaluate the activities of the Department.

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	- *A website would have to be developed and maintained with all information relating to health services, including financial and performance details;* - *This Division would function as the secretariat for the Commission on Health that has been recommended to be established.*	
14.2.2	*The statistical (HMIS) offices in the districts may be established with adequate computer facilities. District level monitoring reports must be produced for enhancing management capacity at the district level;*	District planning and monitoring are effected
14.3	**HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS)**	
14.3.1	*A **comprehensive Health Management Information System (HMIS)** should be put in place by end of the year 200I to enable the Health and Family Welfare Department to improve its service delivery. This should include the following elements:* - *Adequately fulfill human power requirements and avoid mis-matches especially in the posting of Medical officers, details regarding all personnel, at all levels, (viz. Number of sanctioned posts & number filled; recruitment, transfers, leave etc) should be computerised and monitored.* - *Details regarding infrastructural facilities – buildings, equipment; etc. should be monitored continually to ensure adequate availability, timely repairs, civil works and so on.* - *A comprehensive Disease surveillance system should be evolved. This should continually scrutinize, monitor, evaluate and plan for control & / or eradication of diseases, especially diseases of Public Health importance and should be useful at grass roots levels for prevention and management of disease outbreaks.* - *The HMIS should be an effective monitoring tool to assess the performance of the system and which provides for informed planning and decision by the DHS. At the same time it should also support micro-planning and management at all levels where action is essential. The performance indicators & protocols required for objective monitoring of all health activities up to the subcentre level should be worked out.*	Comprehensive Health Management Information System comes into place to effectively assist all activities of the Department.

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14.3.2	*To increase the efficiency and validity of reporting mechanisms, the minimum required data that has to be collected should be identified; integrated reporting formats should be developed and adequate supply of registers/ forms especially at the subcentre level should be ensured.*	Reporting improves
14.3.3	*The Human power and Infrastructure data, Disease surveillance system and a geographical information system (GIS) should be integrated into one computerized system Computerization which is envisaged at the District and State level initially, should be extended to the Taluka and PHC levels at the earliest.* *The staff at decision- making levels should be trained to use the HMIS & GIS effectively for micro-level action and planning.* *Training in basic computer literacy including GIS System and data entry and analysis of all categories of staff involved should be effected.* *Connectivity and communication systems between the different health institutions, offices and levels should be established. To start with all 27 Districts and Directorate should be connected. Later all Talukas could be connected.* *An expert panel should monitor and upgrade the system to keep up with the constant and rapid evolution in IT.*	All data are computerized helping prompt and easy action.
14.3.4	*The present system concentrates on information on communicable diseases. It should also get geared up for* ***management of non-communicable diseases****, especially with the changing patterns of diseases due to urbanization, industrialization, pollution, changing life styles and life expectancy.*	All information regarding communicable and non-communicable diseases become available.
14.3.5	*The web page of the department should be constantly updated. It should be maximally utilized not only for awareness and information but also as a means for promotion of transparency.*	The information is made available to all
14.3.6	*In the long run mechanisms to utilize the computer networking for "**Distance-Learning**" programmes, "**Tele Medicine**" etc. for the health personnel, and for Health Education and Health Promotion activities for the community could be identified and implemented*	The information is utilised effectively for education and promotion of health.

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	15. HEALTH FINANCING	
15.1	*A study of the availability and financing of health services provided by the State, by local authorities and by the private sector should be carried out;*	Reliable data become available of the financing of health services.
15.2	*Parameters should be evolved for rational allocation of funds to districts and sub-regions to ensure a degree of equity in availability of services, with flexibility being built in for special circumstances, taking into account the health plans of the Zilla Panchayats;*	Greater equity is assured.
15.3	*An **internal review** of specific allocations is necessary to reflect the needs of certain essential activities in a realistic manner. This would be particularly necessary in the case of supporting and infrastructure services. Some of the critical areas which would need enhanced allocations would include repairs of vehicles, equipment and buildings, touring for better supervision and administrative charges of the PHCs;*	Improved allocations to critical areas.
15.4	***Budgetary cuts should not be made** in allocations for health services. Such cuts destroy continuity and levels of services built up over time and only prove counterproductive in the long run;*	Continuity of services at optimum level is assured.
15.5	*It should be ensured that release of funds and sanction orders are issued well in time and that the quantum of funds released should be adequate since such releases, in combination with sufficient financial delegations, would ensure maintaining and improving health services;*	Improved utilisation of finances in time and, therefore, optimum services.
15.6	*It is necessary to **ensure coordination** in the budgeting of the various Departments and Divisions of the health and medical services. This responsibility may be assigned to the Commissioner as a coordinating officer, with authority to call for information from associated Departments / Directorates. The Planning and Monitoring Division to be established directly under the Commissioner may be assigned this role. To assist this Division a post of Financial Adviser be created in this Division. This post could be filled by a health economist or by selection, based on experience, from the State Accounts Department or Planning cadres of Government;*	Improved budgeting

Sl.No.	Major Recommendations	Outcome expected
15.7	*The need for the current large number of distinct accounts offices in various Directorates / Departments of the health services results in lack of coordination. The possibility of their integration would have to be studied.*	The study will bring out information, based on which action can be taken on integration of the accounts offices
15.8	*The **adequacy and implementation of financial delegations** within the health services would need review. This may be done by a Committee under the Chairmanship of the Commissioner.* *Nonperformance due to non-utilization of delegated authority should be one of the parameters for assessing annual performance;*	Delegation of financial powers appropriate to the level of responsibility; the officers will be accountable for performance.
15.9	***Internal procedures for monitoring expenditure**, particularly in the case of acquisition of equipment and infrastructure, would need to be reviewed to ensure expeditious utilization of allocations in the best manner possible;*	Better utilisation of the funds.
15.10	*The reporting system and formats prescribed for the field level officials, particularly the ANMs, would need to be reviewed to rationalize them and reduce workload.*	Rationalisation of the reporting system at the field level
15.11	*A comprehensive review of the financial reporting system is necessary so that it becomes part of the HMIS that has been recommended;*	A rational financial reporting system is in place.
15.12	*The system of user fee is a good feature and should be periodically reviewed to enhance both the base and the scale of fees, if called for. It would be necessary to reiterate that the collection of user fee by a hospital would be exclusively meant for its improvement;*	Periodical review and revision of user fee to be used by the hospital, where the fees are collected
15.13	*Schemes for **community insurance** based on Self Help Groups for non-hospitalization cases or with involvement of national insurance companies for hospitalization cases should be formulated and tried out on a pilot basis to develop a replicable model;*	Community insurance to be tried out on a pilot basis.
15.14	*A scheme for **liability insurance for doctors** in the Department, including group insurance schemes, needs to be formulated in consultation with public sector insurance companies, including the Karnataka Govt*	A scheme of insurance against claims of damages to be worked out.

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	Insurance Department. The scheme may stipulate that doctors meet half the costs of the premium;	
15.15	***Norms for health services** based on adequacy of services and quality should be developed as guidelines for formulation of budget requirements. These norms would also provide guidance for assessment of the financial elements of the perspective plan for health services;* *Norms in terms of both quality and adequacy, with regard to expected outcomes of expenditure need to be evolved for monitoring of efficiency of use of funds. Such norms must be developed for various functional levels, including the Zilla Panchayats;* *The long-term requirements of health services would need to be assessed on the basis of the norms suggested above and on the basis of the perspective plan for health services. In assessing these requirements, the requirements to sustain the assets and services created at considerable cost through externally aided projects must be built in.*	Norms would be available for budgeting and other requirements.
15.16	***Test audit** through chartered accountants may be tried on a pilot basis for evaluating the performance of health services at PHC and taluka levels and also to induce a sense of financial discipline. A pilot audit could be instituted in consultation with the Institute of Chartered Accountants. The Planning and Monitoring Division could be the nodal office for this pilot study;*	Auditing of PHC would be done, first as a pilot study and extended if found feasible and useful.
15.17	*A study is necessary of the scale of health services and the financial outlays on such services in Municipal Corporations and other municipal bodies to assess the total health expenditure on health in the public domain. Such a study would help in assessing the needs in urban areas.*	The financial and other needs of the urban areas become known.
15.18	***A study of costs** on health services to families may be conducted, after an evaluation of the results of studies already available, for guidance regarding enhancement of services for the economically weaker section of society at affordable costs;*	A major part of the health expenditure is met by the family, which makes the family impoverished; affordability of services must be known.

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15.19	*The **staffing pattern** would need to be reviewed at intervals to determine both adequacy and excess and critical shortages. A Staff Inspection Unit trained in Organization and Management principles could be assigned this task;*	Adequate staffing is critical in the optimum functioning of health care services.
15.20	*A **financial database** may be built up as part of the composite HMIS that has been recommended for the health services. The system of computerization of financial information and of the accounts should be built up without delay.*	The financial needs and utilisation will be known.
	16. RATIONAL DRUG MANAGEMENT	
16.1	*Procedures should be established for quantifying the essential drugs required for the State, to optimize the **pooled procurement through the Rate Contract.** The Zilla Panchayats may make use of the rate contract for 90% of their requirements, reserving 10% for discretionary purchase.*	The quantity of the essential drugs required are known to get advantage of the bulk purchases through the Rate Contract System.
16.2	*Procedures should be established for developing, disseminating, utilizing & revising **Standard Treatment Guidelines.***	Standard Treatment Guidelines are worked out to improve the outcome of treatment.
16.3	*Procedures should be established for developing & revising **Essential Drug Lists and a State Formulary** based on treatment of choice for the level of expertise- primary, secondary, tertiary, speciality and teaching.*	Essential Drug Lists based on level of expertise available and Formulary for institutions at different levels become available.
16.4	*Every hospital should have a **Drugs & Therapeutics Committee** for monitoring & promoting quality use of medicines. Specific guidelines for Rational Use of drugs, especially, Antimicrobials and Analgesic are a must. Use Generic names of drugs for procurement, supply and prescribing. Implement problem based training in pharmacotherapy in undergraduate medical & paramedical education based on Standard Treatment Guidelines to promote Rational use of Drugs. Encourage problem-oriented in-service educational programs by professional societies, universities, & the min-*	Rational Use of Drugs will be assured.

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	istry of health & require regular continuing education for licensure of health professionals. *Stimulate an interactive group process among health providers and consumers to review & apply information about appropriate use of medicines. Train pharmacists to be more active members of the health care system & to offer better advice to consumers about health & drugs.* *The concept of Drug Information should be popularized among the health care professionals & the public. Drug Information Centre must be accessed for unbiased, objective information.* *The Services of the* ***State Karnataka Pharmacy Council*** *may be utilized for all the above purposes.*	
16.5	*Monitor adverse drug reactions so that appropriate and early measures can be taken to ensure safe use of drugs. Encourage active involvement by consumer organizations in public education about drugs and allocate government resources to support these efforts.* *Procedures should be established to ensure proper labeling of drugs. The packages and the inserts should be adequately labeled to enable people to use drugs properly. It should also mention most common side effects and danger signals, special precautions in case of children, pregnant and lactating mothers, and old people. The labeling should be printed in adequately bold size. The labeling in case of O.T.C. drugs should be more detailed, giving all indications, contraindications, common side effects and danger signals. The labeling should be made in English, Hindi and the regional language.*	Improved safety in the use of drugs.
16.6	*The* ***Government Medical Stores*** *and the District Stores to be re-organised to ensure proper and on-time distribution of all essential drugs. Monitoring of drugs to be received from the centre, their actual receipts and supply to be monitored vigorously.*	The Medical Stores at the State headquarters and districts are re-organised for greater efficiency and effectiveness.
16.7	*The* ***Drug Control Department*** *to be re-organised with sufficient number of Drug inspectors and Drug testing laboratory. Regulation of Drug Company's Promotional Activities is important. Promotional literature for phar-*	The Drug Control Department is able to perform its duties better.

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	maceuticals, guidelines for sponsorship of Symposia and Other Scientific Meetings, Advertisements, Free samples of prescription drugs for promotional purposes, Post-marketing scientific studies, surveillance and dissemination of information should conform to guidelines.	
16.8	*A strategic approach is to be developed to improve prescribing in the private sector through appropriate regulation & long-term association & collaborations with professional associations.*	More rational use of drugs in the private sector also.
16.9	*In view of the trends in increased use of traditional medicines, it is essential to facilitate the establishment of regulation and registration of traditional medicines.*	Better regulation of the use of traditional medicines.
16.10	*The services of the **Karnataka Antibiotics and Pharmaceuticals Limited** to be made full use of, for the production of quality drugs needed by the State.*	Better use is made of the facilities of Karnataka Antibiotics and Pharmaceuticals Limited.
	17. LAW AND ETHICS	
17.1	*Implement effectively the existing laws affecting health and health care, and especially the laws such as the Human **Organs Transplant Act, 1994 and the Prenatal Diagnostic Techniques Act, 1994.***	Effective implementation of the existing laws is assured.
17.2	***Renew the registration** of health professionals in the State once in 5 years, with evidence of sufficient credits of having participated in approved continuing education programmes.*	Prevention of obsolescence and upgrading of competence.
17.3	*The respective professional councils should ensure that the members of the profession practice ethically, following their codes of conduct.This may be done through an amendment of the respective Acts.*	It is the duty of the professional councils to ensure that the members practise ethically.
17.4	*Enact a **comprehensive law to ensure registration** and quality assurance of all health care institutions in the state, on the lines suggested by the Task Force and forwarded to the Government. Promote accreditation.*	Quality assurance and continuous quality improvement.
17.5	*Enact a **comprehensive Public Health Act**, based on the*	An effective and comprehensive

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	Model Public Health Act (1987) with suitable modifications.	Public Health Act is in place.
17.6	*Examine in depth the problem of quackery and take effective steps to stop it.*	Quackery, which is a hazard to the health of the people, is reduced.
17.7	*Arrange for monitoring of the activities under the Human Organs Transplant Act, by an independent agency, to stop the sale of organs. The Institutions should actively promote cadaveric transplants and those performing more than 20% unrelated live donor transplant of kidneys should not be re-certified. There should be dialysis in all district hospitals.* *The Appropriate authority for Organ Transplantation may be reconstituted with inclusion of representatives of voluntary organisations.*	The sale of organs is reduced; more cadaveric transplants are encouraged.
17.8	*Every health care institution to have* ***a Charter of citizens rights and rights of patients****. The Charter should be displayed prominently.*	Greater transparency and integrity. Rights of patients are honoured.
17.9	*Update the "****Prohibition of Smoking Act****". Ensure the welfare of tobacco growers when cultivation is restricted & of beedi workers when manufacture & use are reduced.*	Use of tobacco is reduced and thereby, the harmful effects on the health of the people.
17.10	*Make the teaching/learning of ethics as part of health professions education.* *Make the health personnel aware of the codes of conduct.* *Have training programmes in medical ethics for all health care personnel and particularly the doctors and nurses.*	The health care personnel practise ethically.
	18. INDIAN SYSTEMS OF MEDICINE AND HOMOEOPATHY	
18.1	*The sanctioned post of* ***Joint Director*** *is to be filled. In the absence of C & R rules the senior person may be placed in charge and duties may be assigned. Existing senior doctors may be designated as District level officers of the respective districts. In 11 districts where there are already hospitals, it can be implemented immediately. These district level officers posts are to be filled by selection based on merit-cum-seniority.*	A senior, experienced experienced person is in charge, at the same time ensuring competence.
18.2	*Dispensaries and hospitals are to be renovated after a survey by the Department. Develop uniform norms for*	Improved facilities in the units of ISM&H.

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	dispensaries and hospitals, with regard to plan, space, infrastructure and staff. *Construct special wards with all amenities atleast in the major hospitals attached to teaching institutions at Bangalore, Mysore and Bellary.*	
18.3	***Establish or relocate units of ISM&H** with necessary infrastructure at CHCs, Taluka and District hospitals.*	Availability of modern medicine and Indian Systems of Medicine and Homeopathy, at the same place; choice is left to the people.
18.4	*Establish herbal gardens in ISM&H units, PHCs and CHCs for utilisation and demonstration for the public with the help of forest department (social forestry).*	Improved use of herbal medicines.
18.5	*Provide **residential accommoation** near the place of work for physicians of ISM&H. If Government accommodation is not available, houses may be taken on rent.*	Availability of doctors of ISM&H is improved.
18.6	*There is an urgent need to make available the facilities for **investigative procedures** with qualified and technical staff in all the hospitals. This can be done in collaboration with the hospitals of modern medicine at various levels.*	Improved availability of diagnostic procedures.
18.7	*The services of **contract doctors** need to be regularized, based on performance appraisal*	Improves the morale of the doctors.
18.8	*The Boards of Visitors are to be re-constituted immediately in order to improve the functioning of the hospitals.*	Better people's involvement.
18.9	*Provide all dispensaries and hospitals with a working **telephone***	Improved communication.
18.10	*Establish the **speciality units of panchakarma and ksharasutra** in all district hospitals first and then taluk hospitals.* *The major hospitals are to be upgraded and enlarged to meet the requirements and demands with adequate human force, equipments and other accessories, after a need assessment.* *Well-planned OP blocks in all the major hospitals of Bangalore, Mysore and Bellary.*	Have speciality treatment available. Major Hospitals are upgraded.

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18.11	*Fill up the vacant post of Siddha Physician in the 10-bedded Siddha ward at Sri. Jayachamarajendra Institute of Indian Medicine, Bangalore.*	The post of Siddha Physician is filled.
18.12	*There is a need to **enhance the budget** provision for procurement of medicines in dispensary atleast to a sum of Rs.36,000/- p.a.*	Increased availability of essential drugs
18.13	*Steps have to be taken to provide hostel facilities in all the major medical colleges.*	Improved accommodation for the students.
18.14	*The **disparity in pay scales of doctors and stipend for internees** of ISM&H and modern medicine may be studied and action taken on priority, to remove the inferiority feeling or low esteem prevailing amongst doctors and students of ISM&H*	Disparity reduced.
18.15	*Study the need for developing appropriate training courses with special modules for paraclinical staff such as Masseurs, Nurses ,Health extension workers and pharmacists and take necessary action*	Paramedical staff become available, with improved quality and numbers.
18.16	*The facilities of the State Institute of Health & Family Welfare should be made use of for the training of ISM&H personnel. The training should include hospital management for those in charge of hospitals.*	Improved training in all aspects including management.
18.17	***CME courses** must be periodically conducted to update knowledge and skills of the practitioners of ISM&H. Sufficient credit hours must be earned for the renewal of registration by Karnataka Ayurveda and Unani Practitioners Board and Karnataka Council for Homeopathic Medicine. Professional and Technical support may be obtained from the teaching institutions (Both Private and Government).*	Constant upgrading of the knowledge and skills of the doctors.
18.18	*10 seats may be reserved in MBBS course in the Government Medical Colleges for eligible ISM&H graduates, 7 for Ayurveda, 2 for Homeopathy and 1 for Unani, to bring about integration.*	There is greater integration and possibility of research into the efficacy of different systems of medicine.
18.19	*All the teaching institutes of ISM&H must take up defined geographic areas in order to effectively execute*	Improved involvement of ISM&H in primary health care.

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	public awareness programmes and for primary health care (through the dispensaries and mobile units). The need for trained ISM&H health workers for extension work may be studied and action taken so that they can take up health promotion work in the villages.	
18.20	***Introductory lessons** on ISM&H systems viz., Ayurveda, Unani, Naturopathy, Yoga, Siddha and Homeopathy should be included in the curriculum of schools and colleges, which would create awareness among the children. The institutes of ISM&H should take up school health programmes in the neighbouring schools.*	Greater respect for all systems of medicine; improved health of school children.
18.21	*An **expert committee** may be appointed to consider the upgradation of the Government Pharmacy after studying TAMPCOL of Tamil Nadu or AUSHADHI of Kerala.* *A Homeopathic Drugs Manufacturing Unit may be started to make medicines in sufficient quantities to meet the demands of the entire state.*	Greater availability of quality medicines.
18.22	*To meet the increasing needs of ISM&H, a post of Assistant Drug Controller may be created and filled up by suitably qualified candidate* *Qualified homeopathic doctor may be appointed as drug inspector to inspect the Homoeopathic manufacturing units.* *The department of ISM&H must prepare essential drug lists for each system. A medicinal plant board may be established which would ensure quality, consistency and price.*	Quality assurance of the drugs under ISM&H.
18.23	***Encourage research.** Appoint a Senior Research Officer in ISM&H. Reconstitute the research advisory committee. Rajiv Gandhi University of Health Sciences may be requested to establish interdisciplinary research board, comprising of experts of ISM&H, modern medicine and scientists of basic sciences. RGUHS may be requested to frame standard guidelines for protocols for thesis / dissertations for postgraduate courses in ISM&H.* *The financial support to PG researches may be enhanced to Rs.2,500/- p.a.* *Encourage research in ISMH through financial support*	Research in ISM&H is improved.

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	for interested and dedicated practitioners and private academic institutions.	
18.24	*Government should provide about 50-100 acres of land for ISM&H in each district for cultivation of medicinal plants, which should be harvested and utilised by the Government Central Pharmacy.*	Improved availability of medical plants.
18.25	*The government should effect immediately the promotions that are due and implement time bound promotions*	Improved morale and better functioning of the department.
18.26	*Appoint a qualified person competent in editing / publishing to effectively bring out publications including health promotion materials*	Publications are brought out on time.
18.27	*Doctors qualified in particular system of medicine should practice only that system; cross practice must stop in the interest of the public and to develop the particular system of medicine.*	Doctors practise only that system in which they are competent.
18.28	*Have a **comprehensive HMIS** for all the institutions and services under ISM&H.*	Improved availability of information for better management.
	19. PANCHAYAT RAJ AND EMPOWERMENT OF THE PEOPLE	
19.1	*The **involvement of the Panchayat institutions** and of the community in providing health services should be encouraged for improvement and enhancement of these services based on real needs. For enhancing such involvement, information should be available to the community and a forum must be developed. It would also be necessary to sensitize the officials in this regard;*	Greater involvement in Panchayat Raj institutions and people for improved health services.
19.2	***Sec. 61 of the Karnataka Panchayat Raj Act** may be amended to establish a separate Committee for health, sanitation and education in the Gram Panchayat;*	The committee concentrates its attention on health, sanitation and education.
19.3	***Training courses** in health for empowering women members of the Panchayats and women community leaders need to be organized. Such empowerment would improve the effectiveness of programmes such as RCH, children's and women's health in the community;*	Improved involvement of women members in health and family welfare.

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19.4	*Model health plans need to be formulated by the Panchayat institutions. Such model plans would assist in developing the health component of the District Development Plan;*	Improved health plans as part of Development Plan.
19.5	*The health hierarchy needs to be oriented regarding its role in the Panchayat system and its relationship with these bodies; monitoring of implementation of State funded activity, supervision and inspection continue to be a direct responsibility of the hierarchy;* *A system of monitoring the health activities of the ZPs by the Commissioner needs to be established;* *The Rural Development and Panchayat Raj Department and the Health Department may develop a system of feedback from the health hierarchies in order to render the mutual inter-active role between the Health Department and the Panchayat bodies more productive;* *It would be necessary to conduct orientation courses / workshops for the health hierarchy so that there is a better understanding of both their role and responsibility in the Panchayati Raj system. The Rural Development and Panchayati Raj Department could organize such courses.*	Better co-ordination between the department of Health and Family Welfare Services and the local authorities, with clear responsibility of the department in all technical matters.
19.7	*The meetings of the ZPs may be regulated according to the circulars of the Department of Rural Development and Panchayti Raj regarding frequency, so as to permit district health personnel, particularly the DHO, to carry out inspections and supervision more intensively;*	The DHOs can plan and implement their other activities effectively.
19.8	*Village communities should be encouraged to form Village Health Committees with wide membership, including representatives of women's groups, the youth, the ANMs, the Anganwadi Workers, and others. The Gram Panchayat is empowered to constitute such committees under Sec. 61 – A of the Act.* *These Village Health Committees would have to be trained in the conduct of meetings, prioritizing local health issues, preparation of health plans, etc. Institutions such as the Institute for Social and Economic Change could be assigned this function;* *The formulation of a pilot project for the formation of*	Greater involvement of the people in all health activities.

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	such Committees, developing necessary training material and sensitization could be assigned to the Institute for Social and Economic Change, Bangalore. The State Institute for Health and Family Welfare should also be involved in the process of sensitization of the official hierarchies.	
	20. STRENGTHENING PARTNERSHIPS	
	PRIVATE / CORPORATE SECTOR, GENERAL PRACTITIONERS AND VOLUNTARY ORGANISATIONS	
20.1	***Enhance the scope/importance of collaboration*** *with the private and voluntary sectors in primary, secondary and tertiary level of health care.* *Involve private sector in preventive and promotive care in addition to curative care.* *Promote partnership between public, private and voluntary organisation.*	Improved collaboration between public, voluntary and private sectors in all aspects of health care.
20.2	*Evaluate and monitor* ***quality of services*** *in the private and voluntary sectors.*	Quality assurance is a must whichever be the sector.
20.3	*NGO cell should be created directly under the Commissioner/DGHS and representatives of voluntary organisations working for the health sector should be members of it. The cell should register all organisations & bring out the annual report of the activities of voluntary organisations. The* ***grant-in-aid procedures*** *must be simplified and the bottlenecks removed, to help better collaboration and remove the feeling of frustration.* *The logistics of partnership concept between the government and voluntary organisation has to be worked out by the central cell and the government. Voluntary agencies should be invited to participate in the preparation of health policies by the Government.*	Co-ordination and credibility. Greater involvement of credible voluntary organisations in health and development.
20.4	*The agencies, have to be used more and more for the effective implementation of National Programmes, spread of health education & act as a watch-dog over the provision of health services within the public/private sectors.*	Better performance of the National and other programmes.

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	21. MULTISECTORALITY AND INTERSECTORAL COORDINATION	
21.1	*The State must establish administrative machinery and Co-ordination committees at the State, district and local levels for intersectoral action for health. These groups must be involved in the preparation of the State plan. Have a* ***High Power Core Committee*** *(intersectoral) headed by the Chief Secretary at the state level and committees at the district level with participation by D.Cs and C.E.Os. The Committees should have representations from Health, Education, Women and Child Welfare, Agriculture, Horticulture, Animal Husbandry. Irrigation, Housing, Industry, Pollution Board and Environment. Subcommittees can be formed to reflect and take action on specific matters.*	Better collaboration between all health related sectors
21.2	*All developmental programmes must have inputs from the health sector to make use of the opportunity to improve health and prevent problems.*	Some development programmes might have adverse effects on health; these can be avoided by action during planning, and implementing.
	Health personnel (Public Health) should be trained to anticipate and find solutions to possible health hazards of developmental programmes. They should continue their association during implementation, monitoring and evaluation of the programme.	
	22. THE KARNATAKA STATE INTEGRATED HEALTH POLICY 2001	
22.1	*The draft integrated health policy should be adopted after dialogue with Directorate of Health and Family Welfare Services, other Government Departments and Public.*	Wide circulation and debates among all stakeholders can improve the policy and its implementation for better health for all.
22.2	*A Commission on Health would be constituted to provide policy inputs and expert guidance to the Directorate of Health Services.*	Enhancing responsiveness of health Services to meet current needs and expectations.