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KARNATAKA

TOWARDS EQUITY WITH QUALITY IN HEALTH

Focus on
Primary Health Care
and
Public Health

Interim Report

April 2000

Government of Karnataka,
TASK FORCE ON HEALTH AND FAMILY WELFARE,
Ground Floor, Public Health Institute Building Annexe,
Sheshadri Road, Bangalore – 560 001
Phone: 2271021; **Fax:** 2277389;
email: khsdp@vsnl.com / healthtaskforce@indiatimes.com
website: http//www.dhskhsdp.com

PREFACE

The Constitution of India places the responsibility of providing for the health of the people, on the State. Article 47 of the Directive Principles stipulates that the State shall raise the level of nutrition and standard of living of the people and improve public health.

It was always recognised that health care and public health could not be viewed in isolation but had to be seen as one of the elements within a package of social welfare measures that would include Nutrition, Drinking water supply and Sanitation, Literacy and education, entitlements of women and children and empowerment of the community. Unfortunately, over the years this holistic approach that all such activities of the State should converge in the creation of a welfare state has been eroded and development facets have tended to get "departmentalised". However, in recent years the emphasis on integrated development has been revived and as part of this process the need to take a close look at the organisation of the Health Services in the State has been recognised by the Government of Karnataka.

Karnataka State has had an impressive record of development and has indeed been a pioneer. The present basic structure has evolved from the system in vogue in the Princely State of Mysore. It has been among the earliest administrations to establish and actively support water supply and sanitation systems, health units and local self-government units in the urban areas. That system was remarkable for its approach to Primary Health Care (with the concept of Primary Health Units) and Public Health (using bio-environmental methods of malaria control since the 1930s, establishment of Birth Control Clinics at Vani Vilas Hospital in Bangalore and Cheluvamba Hospital in Mysore, and health personnel being sent for training in Public Health in India and abroad). The addition of other geographic areas following the reorganisation of the States and concepts and structures brought about by the Centre has produced changes. But, the basic structure remained and this has been a strength of the system. It has also been in the forefront of establishing the Panchayat Raj system.

The same spirit has guided its approach to the Health System and the State has an impressive health administration combined with a network of health facilities and educational institutions for health professionals. The Chief Minister, in keeping with the forward looking role of the Government of Karnataka in development, considered that there should be a review of the current state of Health System so as to ensure "Health for All", with equity and quality, for the people of the State within as short a span of time as possible. This concern has been reflected in the constitution of the Task Force.

Many features of the Health System today are the result of historical processes. The character of these Health Services has moved away from a public health perspective to one with major emphasis on clinical (curative) services. This imbalance needs to be rectified. There are also other important issues that merit attention. These include the state of accountability of Health Services to the people, and the need to ensure equity in accessibility, adequacy and quality of services. A review must address several aspects of the Health System. These range from the organisation and management of the health services to the location of service facilities ensuring access to these services without hidden costs, management of the drug supply system and ensuring availability of trained personnel. There are related issues such as of the content of medical education so, as to inculcate an appropriate value system in personnel, the providing of choice for the people between Indian Systems of Medicine & Homeopathy and Allopathy.

Active involvement in the monitoring and management of the health system by the community would make the official mechanisms more responsive and responsible in the discharge of their duties. In this context, the panchayat system has a crucial role to play. How best such an inter-face could be developed would engage the attention of the Task Force.

It is also recognised that the health system cannot function in isolation. Health issues cannot be narrowly defined and confined to merely preventive and curative services. The health of a nation is closely dependent on the nutrition status of the population, the special measures necessary to enhance reproductive and child health and the need to ensure equity in distribution of all social services to the disadvantaged groups. The ability to take advantage of the entitlements in the system is dependent on the ability to access information, which itself is dependent on literacy. The health of future generations depends on the networking of various sectors of development. The mechanisms for such inter-sectoral coordination would also merit attention.

The Task Force is conscious of the duty cast on it. It has set for itself three main tasks.

1. a review of the present health system to determine if it meets its objectives and to recommend measures for improvement,
2. to revitalise and reinstitutionalise the public health character of health services
3. to render operative the mechanisms for involvement of the community in the management of the health services.

In doing so it would assess the current scene and determine courses of action that would go a long way in improvement of the health system. The prime objective would be to commence a process that would result in

the system being able to deliver, with quality and equity, the health entitlements of the people.

This report is an interim report. It deals mainly with the short-term recommendations, which can be implemented within a period of 6 months. It gives also indications of areas of concern, which can be accomplished in the medium (6-24 months) and long term (2 to 5 years). These will be reflected on further. The approach is to ensure sustainability of the initiatives. The interim report will be the basis for wider discussions. A final comprehensive report will then be made. This Final report will contain in addition to the recommendations on specific issues, a Draft State Health Policy and a Perspective Plan. It will also have a Vision Statement.

(Sri Arvind G Risbud)
Member Convenor
(3-3-2000 till date)

(Dr. H Sudarshan)
Chairman

Members:

(Dr. Chandrashekar Shetty S)

(Dr. Francis C M)

(Dr. Jacob John T)

(Dr. Jayaprakash Narayan)

(Dr. Kamini Rao)

(Dr. Latha Jagannathan)

(Dr. Maiya M)

(Dr. Nagalotimath S)

(Sri Padmanabha P)

(Dr. Suresh B Kulkarni)

(Swami Japananda)

(Dr. Thelma Narayan)

Member Convenors

(Dr. S Subramanya)
(21-12-1999 to 14-2-2000)

(Sri A K M Nayak)
(15-2-2000 to 3-3-2000)

CONTENTS

GLOSSARY

AIR	All India Radio
ANM	Auxillary Nurse Mid-wife or Junior Health Assistant (Female)
CNA.	Community Needs Assessment
CBO	Community Based Organisation
CBR	Crude Birth Rate
CDR	Crude Death Rate
CFTRI	Central Food Technology and Research Institute
CHC	Community Health Centre
DD	Doordarshan
DHO	District Health Officer
DHFWS	Directorate of Health and Family Welfare Services
DISM & H	Directorate of Indian Systems of Medicine and Homeopathy
DME	Directorate of Medical Education
DHF/ DSS	Dengue Haemorrhagic Fever and Dengue Shock Syndrome
FOGSI	Federation of Obstetrics and Gynaecologists Societies of India
FRU	First Referral Unit
GMS	Government Medical Stores
HIV/ AIDS	Human Immunodeficiency Virus / Acquired Imuuno Deficiency Syndrome
HIMS	Health Information Management System
ICDS	Integrated Child Development Services
IEC	Information, Education, Communication
IFA	Iron and Folic Acid
IMR	Infant Mortality Rate
ISEC	Institute of Social and Economic Change
ISM&H	Indian Systems of Medicine and Homeopathy
JD	Joint Director
JE	Japanese Encephalitis
KMIO	Kidwai Memorial Institute of Oncology
LEB	Life Expectancy at Birth
MLA	Member of Legislative Assembly
MLC	Member of the Legislative Council
MCH	Maternal and Child Health
NFHS	National Family Health Survey
NGO	Non Governmental Organsiation
NIMHANS	National Institute of Mental Health And Neuro Sciences
NRR	Net Reproduction Rate
NTI	National Tuberculosis Institute
NTP	National Tuberculosis Programme
OOD	On Other Duty
ORS	Oral Rehydration Solution
PD	Project Director
PDS	Public Distribution System
PHC	Primary Health Centre
PHU	Primary Health Unit
PLA	Participatory Learning and Action
PRA	Participatory Rapid / Rural Appraisal
RCH	Reproductive and Child Health
RDPR	Rural Development and Panchyat Raj
RGUHS	Rajiv Gandhi University of Health Sciences
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive Tract Infection
SC &ST	Scheduled Castes and Scheduled Tribes
SGARRC	Sanjay Gandhi Accident Relief and Rehabilitation Centre
SIHFW	State Institute of Health and Family Welfare
STI / STD	Sexually Transmitted Infection / Sexually Transmitted Disease
TFR	Total Fertility Rate
UTI	Urinary Tract Infection
UGC	University Grants Commission
VO	Voluntary Organisation
ZP	Zilla Panchayat

THE PROCESS

The Government of Karnataka under the leadership of the Chief Minister, Sri S M Krishna, constituted the Task Force on Health and Family Welfare with Dr. H. Sudarshan as Chairman (Annexure 1).

The terms of reference were broad and included:

1. Suggestions for improvement of Public Health in the State;
2. Proposals for stabilization of the population;
3. Recommendations to improve management and administration of the Department of Health and Family Welfare;
4. Recommendations for changes in the education system covering both Clinical and Public Health; and
5. Monitoring the impact of the recommendations, especially in the initial stages of implementation.

The process adopted has been **participatory** in nature. The deliberations have been undertaken with the spirit of inclusion and involvement.

The Task Force had 28 sittings starting on 21st December 1999 (Annexure 2). The Principal Secretary, Health and Family Welfare, addressing the members made it clear that the Task Force may deliberate on any issue it feels concerned about apart from those mentioned in the terms of reference and invite any person who can contribute to the deliberations.

The Task Force formed subgroups, to consider the issues better (Annexure 3). The Task Force has attempted to review the situation with the implementers, experts, policy and decision-makers, administrators, and the public. Many individuals, organizations and associations have been consulted (Annexure 4). The consultations included:

a) Dr. A B Maalaka Raddy, Minister of Health and Family Welfare, Karnataka and Smt Nafees Fazal, Minister of State for Medical Education, Karnataka
b) The Principal Secretary (Health), Government of Karnataka; The Secretary, Medical Education, Government of Karnataka; The Commissioner for Health and Family Welfare;

The Project Administrator – Karnataka Health Systems Development Project; The Project Director - India Population Project IX; The Deputy Secretary, Health.

c) The Directorates of Health and Family Welfare Services, Medical Education and Indian Systems of Medicine and included the Directors and other Officials from the State, District, Taluka and Primary Health Centre Level.

d) Health Officials from Bangalore Mahanagara Palike - The Health Officer and the Project Co-ordinator, India Population Project VIII.

e) Representatives from the Professional Bodies - Karnataka Medical Council, State Councils for Indian Systems of Medicine and Homeopathy, Dental, Nursing and Pharmacy, Indian Medical Association, Associations of Karnataka Government Medical Officers, Ayurvedic Physicians, Medical and Dental Teachers Association, Contract Doctors, Integrated System of Medicine, Federation of Obstetrics and Gynaecological Societies of India, Indian Academy of Paediatrics.

f) Representatives from Voluntary Organisations and Associations networking in the area of Health - Voluntary Health Association of Karnataka, Catholic Health Association of India-Karnataka, Christian Medical Association of India, Society for Service to Voluntary Agencies - Karnataka Chapter, Federation of Voluntary Organisations for Rural Development in Karnataka, Family Planning Association of India, Community Health Cell, AIDS Forum Karnataka, Foundation of Organ Retrieval and Transplant Education.

g) Representatives from Autonomous / National and Premier Health Institutions of Karnataka - National Institute of Mental Health and Neuro Sciences, National Tuberculosis Institute, Regional Occupational Health Centre, Kidwai Memorial Institute of Oncology, National Institute of Virology, National Institute of Communicable Diseases, Regional Office of health and Family Welfare, National Law School of India University, Malaria Research Centre, Indira Gandhi Institute of Child Health, Institute of Social and Economic Change, Sanjay Gandhi Accident Relief and Rehabilitation Centre.

h) Representatives of Corporate Hospitals, Teaching Hospitals, Private Hospitals and Association of Nursing Homes and Private Hospitals.

Health determinants are multidimensional and multi-sectoral. An interaction was undertaken with sectors, which influence Health. They included the Departments of Women and Child Welfare, Education, Agriculture, Urban Development, Food and Civil Supplies, Social Welfare,

Environment, Ecology and Forests, Rural Development and Panchayat Raj. Another important area of Interaction was with representatives of Consumer Groups, Women's Organisations, Civic / Citizen Groups, Peoples Organisations and Movements and Corporate Bodies.

Recognising the crucial role of **Print and Electronic Media** consultation was held with representatives of the media (Annexure 4). Press releases were made in the National, State and local Newspapers both in Kannada and English, requesting the Public to contribute towards the deliberations of the Task Force (Annexure 5).

Experts both within the State and outside were invited to share their concerns and suggestions for improvement of health.

Elected representatives are the Policy and decision makers. An interaction- discussion was scheduled with the **MLAs, MLCs and ZP members**. Letters were also addressed to all the MLAs, MLCs and Zilla Panchayat Presidents requesting them to contribute towards the deliberations of the Task Force. Sri P G R Sindhia, MLA and formerly Health Minister, Karnataka, met the Task Force, while Sri Kariyanna, MLA, Sri Cheluvanarayana swamy MLA, Sri Chikkamadanayaka, MLA, and Sri Ramesh Kumar Pande, MLA and Sri NeelakanthaRao Deshmukh Garmpalli, President Zilla Panchayat (Gulbarga) sent their views in writing.

An attempt was also made to study the policies and provisions for Health Care Delivery in **other States** of our country by dispatching request letters to the Health Secretaries of the States and Union territories of the Union of India.

The Task Force was happy to meet and interact with the Secretary to Health, Indian Systems of Medicine, Government of India.

The members of the Task Force individually or in groups **visited the different districts** to interact and understand the ground realities. Discussions were held with the Zilla Panchayat members, Chief Executive Officers, District Health Officers, District Surgeons, Taluka Health Officers, Primary Health Centre staff and the public. In addition, detailed interactions were held with the

District Health Officers and District Surgeons during their monthly meeting. Members of the Task Force also **visited some of the institutions**.

The above efforts of the members of the Task Force **provided a large body of information and evidence**. The process brought forth various issues and concerns. Some required simple interventions. Some related to the structural changes and policy decisions. These needed much more detailed study and would have long term implications.

Recognising and realising that each one of us can immediately contribute towards ensuring **equity** with **quality** in health for all of our people, this Interim Report is presented. The suggestions and recommendations herein have been discussed with the Secretaries to the Government, and the Directors of Health and Family Welfare, who have to take action to implement them.

The Terms of reference also gives the Task Force the mandate for monitoring the implementation of its recommendations and the outcome. An agenda for immediate action has been drafted. An indicative Plan of Action towards implementation of the short-term recommendations is given as the last chapter of this report. A comprehensive Plan of Action for the implementation of all the recommendations (including medium and long term) and monitoring the outcome will be drawn up in consultation with the Directorate of Health and Family Welfare Services.

Over the next 6 months, the members of the Task Force will identify for themselves specific monitoring components, the objective being to enable and empower the system to deliver better health care services. The endeavour would primarily focus on working with individuals and structures in the system and arriving at desirable outcomes.

The Task Force intends to incorporate all the recommendations of facilitation in the final report. It is hoped that this process will result in a comprehensive State Health Policy, which will include the components of Health, Population, Nutrition, and Rational Drug Use.

AN OVERVIEW

Karnataka has done well in many aspects of Health. But, there have been areas where it has not performed as well as it might have. Hence, Karnataka has been often described as an "average" State with respect to the health of its people. There are many strong points of which Karnataka can be happy about. The Task Force has tried to identify these areas of strengths and build on them. But, there are also many issues and areas of concern. The Task Force has interacted and deliberated and will continue to address them. A few key messages have come out of the deliberations, reflections and suggestions from within the Health System and outside it.

STRENGTHS AND ACHIEVEMENTS OF THE KARNATAKA'S HEALTH CARE SERVICES

The Government of Karnataka has over the last few decades taken measures to improve the health and wellbeing of its citizens in line with the constitutional pledges, National Health Policy guidelines and the State's own policy initiatives. The Task Force through all its interactions and reviews to date identified the following areas of strength and health care issues on which the State has achieved a great deal. By recognising them the Task Force hopes to indicate the context and base on which a comprehensive and people oriented Health Policy can be enunciated and put into action.

1. Karnataka State has emerged as having an overall health status and health care delivery system **above the national average** inspite of some continued inter-regional disparities.

2. A **wide network of Health Care Institutions** – primary, secondary and tertiary levels - have been established in the State on a planned basis using population norms. They provide comprehensive health care and the services are utilised more by the poor.

3. State policies have fostered the establishment and running of Medical, Nursing and other **health professional educational institutions**. A large number of Doctors and Nurses and other health humanpower have been trained. The establishment of the **Rajiv Gandhi University of Health Sciences** has brought under one umbrella over 240 educational institutions training health humanpower for the State. This augurs well for the evolution of a more relevant, rational and need based Health humanpower development for the State. Trained graduates from these institutions whether working in the public / private / voluntary sector have increased access to health care.

4. There has been an overall **improvement in the health status of the people evidenced** by

- Increased Life Expectancy at Birth from 26 years in 1947 to 66.3 years for women and 65.1 years for men in 1997.
- Decline in Crude Birth Rate from 41.6 to 22.7 / 1000 population from 1961 to 1997.
- Decline in Crude Death Rate from 22.2 to 7.6 / 1000 population from 1961 to 1997.

Infectious Disease

- **Eradication** of smallpox, plague in humans, and most recently guineaworm infestation.
- Control to a considerable extent of **Vaccine Preventable Diseases** such as polio diphtheria, whooping cough, tetanus and to a smaller extent measles.

Family Welfare

- The effective **Couple Protection Ratio** has increased from 23.8% in 1981 to 57.7% in 1997

5. Some of the **other policies and initiatives** in the State:
    - The **Externally Aided Projects** have contributed to the infrastructure available for health care delivery and to the efficient and effective work cultures.
    - The **Community Mental Health** initiative in Bellary
    - The State has been entering into **partnership with Voluntary Organisations** for the more efficient and effective running of Primary Health Centres
    - The State has also recently made available **anti-tubercular drugs** to fight the menace of Tuberculosis in the entire State.
    - The State has brought out the report on **Human Development in Karnataka, 1999**

    These indicate the **growing sensitivity** to Health care needs and addressing the formidable challenges of Equity in Health and Development.

6. Karnataka has in the past regularly invited participatory evolution of Health Care initiatives and **dialogue** with professionals and voluntary organisations. The involvement of NGO's has been sought in the past in the Development of the **perspective plan** for Government of Karnataka (1989-2004); the preparation of the plan documents and brainstorming on other policy initiatives as well.

7. Perhaps the greatest strength seems to be the **increasing openness and receptivity** among the health policy makers – both bureaucrats and technocrats - to ideas and suggestions from a wide cross-section of professional and public opinion.

ISSUES OF CONCERN

The Task Force had a very wide ranging interaction with a large number of health care providers, decision makers, policy makers, representatives of professional associations, voluntary and private sector organisations and representatives of civic society. The discussions were open, frank, in a spirit of dialogue and very constructive. Concerns were shared and suggestions and ideas to improve the health care system in Karnataka were freely given.

Some issues of general concern emerged from all these interactions.

1. **Neglect of Public Health**:

   There was an overall neglect of public health principles in planning, organisation and management of health care services with not enough emphasis on preventive, promotive and rehabilitative care; and even less on the determinants of health including nutrition, water supply and sanitation and the social determinants.

2. **Distortions in Primary Health Care** :

   The promotion of Primary Health Care as a policy thrust was distorted by various factors, which included:

   (a) Inadequate efforts at community partnership and ownership of programmes including effective decentralisation to Panchayat Raj Institutions.
   (b) Increased verticality and selectivisation of programmes at the cost of horizontal integration and comprehensive approaches.
   (c) Lack of intersectoral coordination and convergence of health and development programmes at the community level.
   (d) Lack of adequate partnerships with General Practitioners, Voluntary Organisations, civic society and the private sector.

3. **Inadequate Attention to Quality:**

   There seemed to be an overall lack of quality orientation and inadequate attention to establishment and maintenance of quality of care standards.

4. **Lack of Focus on Equity and Regional Disparities**:

   Regional disparities and differences were being inadequately addressed. The monitoring of equity as a policy imperative was insufficient - be it regional inequities, gender inequality or class/caste inequities, at least partly due to absence of monitoring health indicators dis-aggregated by equity related factors.

5. **Lack of Leadership and low Morale of Health Team:**

The leadership at the Health Department seemed to be inadequate leading to a low morale at various levels. Visionary and inspirational leadership to reach the stated goals with the full involvement of the health team and community as partners was lacking.

6. **Corruption:**

There was widespread and growing 'corruption' at various levels of the system, which seemed to be compromising quality, efficiency and management. The areas affected included monetary consideration for appointment, promotions, transfers; corruption within the selection of candidates as well as the examination systems; and monetary factors distorting access and utilization of health care services at different levels. The "canker" seemed to be widespread and well entrenched into the system.

7. **Lack of Political Will:**

Health did not seem to figure high on the political agenda of governance. Health budgets were stagnant; often under utilized; and the political will to get plans off the ground and reach those who need to be reached was lacking. Especially, the continual of key and critical vacancies not being filled up. Individual agendas rather than collective good predominated.

8. **Poor Governance**:

The planning administration, monitoring and evaluation of the health system was poor, often adhoc, and not always evidence based. Problem solving oriented leadership development at all levels was seriously needed. There was an overall lack of comprehensive perspective or vision, too much compartmentalisation of programmes and initiatives, often leaving the forest for the trees.

9. **Human Resource Development Inadequately Addressed:**

There was a neglect of planning and policy for human resource development and deployment - types of health team, qualities and complete team development; continuing education; promotion and career development policy; accountability and maintenance of morale. The commercialisation of Professional education has led to poor quality of training and mushrooming of educational institutions.

10. **Lack of Integration of Externally Aided Projects into Health System Planning:**

A range of externally aided projects, through grants and loans, have been inadequately integrated into the overall health system planning due to compartmentalisation; parallel system development; inadequate monitoring of potential distortions; policy and conditionalities of funding partners; inadequate policy reflection on issues of sustainability, accountability and transparency.

KEY MESSAGES

A reflection on the interaction-deliberations of the Task Force has brought forth Key Messages addressing the concerns and building on the strengths.

1. **State Health Policy**

   Need for a State Health Policy which is comprehensive and integrates Health, Population, Rational Drug Use and other concerns; which is located in the context of a long term perspective planning process and built into the Health System.

2. **The Equity Imperative**

   Need for urgently tackling regional disparities in Health with an equity focus on the rights, status and access for women, children, Scheduled Castes and Scheduled Tribes, marginalised groups, the Persons With Disabilities and the aged.

3. **Revaluing Public Health**

   Need for strengthening Public Health competence and skills at all levels of the system to improve Health for All without distinction or discrimination and tackling the determinants of Health rather than only responding to the biomedical aspects.

4. **Making Primary Health Care work**

   Making Primary Health Care work by improving quality of the primary Health services through strengthening of human power resources, services and referrals. At the same time strengthening the community partnership and ownership of programmes through decentralised Health action through Panchayat Raj Institutions, civic society mobilisation and devolution of administrative and financial powers.

5. **Quality Assurance**

   Quality improvement in the management of Health services through training and continuing education of the Health teams; increasing competence and quality of care; increasing focus on efficient supplies and logistic support; preventing duplication and/or compartmentalisation of services and strengthening quality monitoring systems.

6. **Investing in Health**

   Making optimum utilisation of the allotted financial resources and increasing budget allocation as necessary for needs and Health for All goals, supplemented by raising the value of Health in the political agenda.

7. **Increasing Accountability and Transparency**:

   Recognising the constitutional and policy obligations of evolving a comprehensive Health policy and Health care system development; ensuring accountability and transparency to

prevent distortions and deviations due to extraneous influences of market economy, lobbies, social and political agendas and money power.

8. **Establishing New Partnerships**

Evolving meaningful partnerships to improve Health and quality of life of the people of the State, through planned involvement of voluntary agencies, general practitioners, private sector and the sections of civic society.

9. **Strengthening Medical Pluralism:**

Strengthening the functions of the Indian Systems of Medicine and Homeopathy and supporting them to widen the choices for the people, particularly at Primary Health Care level.

10. **Exploring greater Intersectorality of Health Development**:

Recognising the intersectorality, central to Health development, and evolving meaningful partnerships with other sectors and ministries of the government which impacts on the determination of Health as well as contributes to the improvement of health development.

TOWARDS EQUITY WITH QUALITY - AN AGENDA FOR ACTION

Major Recommendations For Implementation In The Next Six Months

The deliberations and interactions-discussions of the Task Force have brought forth issues and concerns and resulted in its recommendations. The recommendations aim at initiating changes in health system towards ensuring Equity and Quality in service delivery. The 12 Point Agenda focus and highlight the actions for immediate implementation based on major recommendations.

1. Strengthening Primary Health Centres and Sub centres

1. All vacancies of Doctors, Laboratory Technicians and ANMs must be filled up immediately.
2. All key staff, including Doctors / Staff Nurses/ANMs, and other essential staff attached to the Primary Health Centres must stay in the quarters. Where repairs are necessary they should be carried out immediately; where there are no quarters action may be taken to construct them; if quarters are not available, houses may be taken on rent.
3. The allotment for Essential Medicines (including Life Saving Medicines) must be increased by atleast Rs. 25,000/- per annum per PHC. All Essential drugs must be available at the PHC at all times.
4. Every PHC must have a working Telephone.
5. Atleast 1000 PHCs in the State must be made fully functional satisfying the above criteria, within the next 6 months.
6. The mobile Health Units and PHCs in Tribal Areas should be made fully functional.
7. The Urban Family Welfare Centres and Health Centres under India Population Project VIII should be involved in Comprehensive Primary Health Care.

2. Referral Services: Secondary and Tertiary Health Care

1. Complete the Secondary Care Institutions in progress under KHSDP (100 Secondary Care Hospitals) in the next Six months and make them fully functional with adequate human power, equipments and accessories. The OPEC Hospital in Raichur must be made functional as early as possible. Work out effective linkages of Primary Health Care Institutions with the referral hospitals.
2. The eight districts in the State which do not have a Blood bank to have atleast one blood bank each.

3. Laboratory Services

1. All laboratories must be staffed with trained technicians. Fresh appointees must be given orientation training before posting and existing staff should be given refresher training.
2. The PHC laboratories must provide prompt and efficient service for the diagnosis of TB, malaria, leprosy, RTI/UTI and other routine investigations.
3. Rs. 30,000/- per PHC to be initially earmarked for the purchase of Microscopes (about Rs. 15,000/-), equipments, glass ware, other accessories and reagents.

4. Strengthening the Public Health System

1. A short two week course on Public Health principles and practice for Taluka and District Health Officers at the State Institute for Health and Family Welfare. Short in-service orientation courses on public health principles and programmes for PHC Medical Officers.
2. One Day Workshop each for Tuberculosis and Malaria to help the rational implementation and vitalise the TB control and Anti-malaria programmes in the state. The participants to include State and District Officers and all Professors of Medicine of all Medical Colleges in the State and representatives of all relevant Professional Associations.

5. Women and Children

1. The role of Dais in safe deliveries should be supported and training enhanced. Disposable Delivery Kits of good quality and cost effective components should be provided.
2. Educate and promote personal hygiene especially during menstrual period by the distribution of subsidised menstrual pads/cloth.
3. Ensure 24-hour Emergency Obstetrics Care Services at CHCs and Taluka Hospitals.
4. To involve FOGSI in RCH Programme at Bellary District.
5. To cater to the Newborn Care, the Anganwadi Worker to be trained to be the second functionary.

6. Health Human Resources Development

1. Moratorium on New medical, Dental, Nursing, Pharmacy and Physiotherapy colleges for the next three years. (exception: Nursing Colleges in the underserved areas). No more essentiality certificate or affiliation to be given. Where essentiality certificate or temporary affiliation has been given but the College has not started functioning, the certificate and affiliation to be withdrawn immediately.
2. Extend the moratorium on new Ayurvedic, Homoeopathy and Unani Colleges by another 2 years.

3. The State Institute of Health and Family Welfare to be upgraded. The Institute and RGUHS together with VOs and experts should take up the training at all levels in Management, Public Health and Ethics.
4. Increase the intake for the training of Auxiliary Nurse Midwives (ANMs) so as to fill the vaccancies at the earliest. Encourage NGOs with the capacity for training to take up the training of ANMs.
5. Every Medical and Dental College to adopt a block for service to the people of the area and training of students.

7. Health Systems Management

1. All administrative posts to be filled up
2. A Vigilance Cell in the Directorate headed by the Commissioner for disciplinary action against corruption, absenteeism and for speedy disposal of enquiries.
3. A transfer Policy to be evolved on the basis of well defined criteria, and implemented. Mismatch of professionals and service requirements to be addressed.
4. About 100 Doctors from the Department to be selected through a transparent "search-cum-selection" mechanism with the assistance of the Task Force, given intensive training in management and placed at the Directorate and DHOs Offices as Programme Managers.
5. Care will be exercised in the procurement, supply and making available all essential drugs, operating the Rate Contract System rationally and effectively.

8. Health Information Management System

1. An integrated Geographical Information System based HMIS to be initiated and implemented.
2. Annual reports and monthly updated programme performance to be placed on website of the Directorate for information.

9. Law and Ethics

1. The legislation introduced in the Legislative Council to regulate the functioning of Health Care Institutions should be sent to a Select Committee to elicit views from all concerned (stake-holders, professionals and public).

10. Indian Systems of Medicine and Homeopathy

1. Plan and initiate action to have ISM&H wings in the existing District / Taluka hospitals.

11. Panchayat Raj and Empowerment of People

1. Training must be imparted to the new Panchayat members regarding their responsibilities and duties, with respect to Health, Nutrition, Drinking Water and Sanitation, Population and co-ordination with the health staff and need for monitoring health programmes.
2. The Gram Panchayat should appoint a woman health functionary at Village where there is no ANM/Anaganwadi Worker for the management of Health, Nutrition, Drinking Water and Sanitation, Population. This could be initiated atleast in a few districts where Human Development Index is low.

12 Strengthening Partnerships

1. Introduce a single window Voluntary Organisations Cell at the Health Directorate to co-ordinate the different programmes and simplifying procedures for grant-in-aid avoiding delays. Commissioner to be the nodal officer.
2. Use the services of private practitioners and specialists where there is lack of such personnel in the Government sector.

1. INTRODUCTION

Changes in the Health System are essential to bring about **equity** and **quality** in the services, which must be available and accessible to the people. The services must be **cost-effective** and **relevant.**

For the health system to run efficiently and effectively, there is need for all the stake holders – the people, the policy and decision makers, the care providers and others - to agree on a set of fundamental values. We believe that the major value in Health Care is **equity with quality**. This was the guiding principle for the call for "health for all". We have to reflect and decide upon the changes to be made in the Health System to uphold the values and meet peoples' needs. This is best done with the full involvement and participation of the community.

The Public demands improvements in Health Care. Their dissatisfaction with the existing system is clear from the large number of depositions by representatives of various associations and still larger number of letters received by the Task Force. Valuable suggestions have been received from the Honourable Minister for Health, the Honourable Minister of State for Medical Education, the Principal Secretary for Health, the Secretary for Medical Education and the Commissioner for Health. The Director of Health Services and his senior colleagues who interacted with the Task Force, have brought forth the drawbacks and problems and suggested changes. Their willingness to change augurs well for improvement in equity with quality. The suggestions are many. Question: **which way to go?**

The Health Care System must accept **accountability** for the health of the people of the State. The System must accept responsibility for the outcome and health status. How effective has the system been in meeting the health needs of the people of the State? Has there been a positive impact on the health of the people? Could it have achieved better results utilising the same resources? Have we been addressing the Health Care priorities? The health system is **socially accountable** for what they do and what they fail to do.

The implementers of the Health System, the 62,000 (sanctioned strength) members of the Government health sector team, play a critical role, in the Medical and Health care of the 52 million people. Hence, careful attention needs to be paid to developing and improving their morale, self esteem and self confidence; to inculcate a sense of pride in the quality of their service. Strategies need to be developed by which their competence is increased. Recognising that strong social forces of hierarchy, class, caste, gender and ethnicity underlie and cross cut all technical interventions and health programmes, explicit planned efforts need to be made so that the health team members, particularly Doctors and Nurses, gain an understanding of the dynamics of the Indian Society.

District Health Plans that are responsive to local health problems should be encouraged. An integrated bottom up approach to health policy fits into the decentralised approach to governance being developed through Panchayat Raj systems. It offers a greater opening for active involvement of people, Community Based Organisations, Voluntary and Private agencies in the Health Policy process of the State. Thus, we will move towards the goal of **Peoples Health in Peoples Hands** and of **Health for All,** particularly the marginalised.

We need a health care system, which is equitable, need based, culturally acceptable, of good quality, cost-effective and sustainable. It should benefit all the people of the State. The focus is on Primary Health Care and Public Health. Improvement in Health Status calls for committed action on the part of all concerned, both within and outside the health sector. The Health Sector is to be responsible for Primary Health Care and surveillance for the control of the outbreak-prone diseases, which forms one aspect of Public Health. Education, Nutrition, adequate Safe Water and hygienic environment are critical elements of Public Health to prevent disease and maintain health. These elements are outside the formal Health Sector. The collaboration and co-ordinated complementary actions among all the relevant sectors are fundamental to **equity and quality** in health.

2. DISPARITIES

Regional inequalities are said to be the legacy for the State of Karnataka. The Human Development Index and Gender Related Development Index computed for the first time (Human Development in Karnataka, 1999) for the 20 districts of the State bring forth the clustering. This important process of documentation has thrown open the great challenge of bridging the developmental gaps.

"Uneven development in Health infrastructure and the delivery of the services in the Northern districts of Gulbarga, Raichur, Bellary, Bijapur, Bidar and Dharwad have led to poor health indicators for these districts" - Human Development in Karnataka, 1999. The district Human Development Index, 1991 was lowest in Raichur followed by Gulbarga, Bidar and Bellary. The Health Index (1991) ranking from the bottom was Bellary, followed by Tumkur, Chitradurga, Shimoga and Dharwad. It is necessary to work out the various health indicies disaggregated for the 27 districts, including 7 new ones. The disparities will be greater if we consider the Talukas. There are also pockets of poor development and health in the better-developed districts. All such areas need greater attention.

Amongst the principal and classical Health indicators are included Life Expectancy at Birth (LEB), Infant Mortality Rate (IMR), Crude Birth Rate (CBR), and Crude Death Rate (CDR). These also show disparities between districts.

In 1991, LEB in Karnataka was 62.07 years (60.6 years for men; 63.61 years for women) In all districts LEB were higher for women than for men. Differences between LEB for men and women varied from one district to another. It ranged from 9 years in Kolar and Hassan to 0.62 years in Bangalore Urban district.

In 1991 IMR was down by 7 points to 74 in comparison to 1981 levels At District level it ranged from 29 in Dakshina Kannada to 79 in Bellary. The decline in CDR has been slow over the last 3 decades. The districtwise estimates varied from 7 in Dakshina Kannada and Shimoga to 10.7 in Gulbarga. The Crude Birth Rate in the 22 districts belongiing to the Bangalore, Belgaum and Mysore divisions varied between 17 and 22, whereas it is between 27 and 30 in the 5 districts belonging to the Gulbarga division (Source: ISEC, Bangalore, Rapid Household Survey- RCH Project, 1998).

In the eighties, the decadal population growth rate declined in all districts except Bidar, Bijapur, Gulbarga and Raichur. The annual compound growth rates of these four districts increased from 1.99% in 1971-1981 to 2.25% in 1981-91 suggesting that decline in mortality has been more than decline in fertility.

Health Care Facilities

There are differences in availability of Health Care facilities in the different districts. In 1996-97 the population per bed in government medical institutions in Karnataka was 1166, and the ratio varied from 395 in Kodagu to 2330 in Raichur district.

There is a need for improvement in Health management especially in the Northern districts where poor management is compounded by large number of vacancies and the less aware and less articulate population.

Facilities and services available in primary level health care institutions are not fully utilised and secondary and tertiary level hospitals are overcrowded. It is estimated that nearly 1/3 of the patients who are currently treated at tertiary level hospitals could well be treated at lower cost in first referral units.

In Bangalore (Urban) District, Belgaum and Dharwad the number of private medical institutions is higher than the number of public medical institutions. The number of private hospital beds is less than the number of public hospital beds except in Bijapur, Dharwad and Dakshina Kannada districts. The number of private hospital beds is quite high when compared to number of public hospital beds in Dakshina Kannada (7334 against 2787)

Among different social groups, it remains a matter of concern that there has been no concerted effort at reducing morbidity and mortality rates among the marginalised (scheduled caste and tribal populations).

In 1995-96, the Couple Protection Rate in Karnataka was about 57%. The proportion varied from 41% in Raichur to 73% in Mandya. In 1992-93, 6.9% of married women in reproductive age group were effectively protected by spacing methods (5.8% IUD and 1.1% Oral pills) and 1.7% of men with wives in childbearing age were using condoms. Between 1956 and 1995-96 the proportion of vasectomies was only 13%.

Gulbarga Division comprising districts of Bellary, Bidar, Gulbarga, Koppal and Raichur, along with Bijapur in Belgaum division tends to be most backward in terms of Demographic, Social and Health indicators.

RELATED ISSUES AND CONCERNS

- An important determinant of health is female literacy. The state average is 44.3%. But it shows great variation between districts. While Bnaglore (Urban), Dakshina Kannada, Udipi and Kodagu show female literacy rates above 60%, it is as low as 21.7% in Raichur, 22.8% in Koppal, 24.5% in Gulbarga and 28.6% in Chamarajanagar. The differential in literary rates is highest in rural areas. Rural female literacy for the State is

as low as 35%. The districts of Gulbarga and Raichur have rural female literacy rates lingering at around 16%. Female literacy in the two remaining districts of Bellary and Bidar in Gulbarga division is also only marginally above 30%. It is a matter of concern that the districts of Belgaum, Bangalore Rural, Kolar, Mandya and Mysore too have female literacy rates below the country average of 39%.

- Analysis of the growth of per capita district income in real terms during the eighties shows that the annual percentage increase, in per capita income was less than 2% in Bidar, Chitradurga, Kodagu, Mandya, Raichur, Shimoga, and Uttara Kannada whereas it was between 4 and 7% in Bangalore, Belgaum, Bijapur, Dakshina Kannada and Kolar.

- 76% of workforce is in rural areas. Despite growth in urban job opportunities, the proportion of the labour force still dependant on low-income-rural-employment is high. Women appear to be replacing men in rural jobs (low and agricultural) consequent to migration of men to towns for better paid employment.

- One of the most important factors is the higher **poverty** level (lower purchasing power). The percentages of people below poverty line in some of these districts were Bidar - 56%, Dharwad - 50%, Kolar - 48%, Gulbarga - 45.5% and Bellary - 44.5%. Bijapur and Raichur which are identical to Gulbarga and Bellary in many deprivation indicators seem to have lower Poverty ratios. The National Sample Survey has found that meeting expenses for medical care is an important cause of indebtedness. Hence, providing access to good quality health care services by the government can help to reduce the poverty spiral and help in development.

GENDER ISSUES

- Most districts in the State have unfavourable Sex Ratios and these are not necessarily only in northern divisions of Gulbarga and Belgaum. What is more disturbing is the decline in the over all Sex Ratio from 963 in 1981 to 960 in 1991.

- The Infant Mortality Rate for females has only marginally improved for the State from 74 in 1981 to 72 in 1991. The ratio was highest in Dharwad district. Bellary, Bidar and surprisingly Shimoga were above the State average. The lowest was in Dakshina Kannada.

- Age Specific Mortality Rates show that 26% of deaths of women were between ages of 15 and 34 in comparison to 15% amongst men.

- The mean age at marriage for girls is low in the districts of North Karnataka especially Bidar, Gulbarga, Raichur, Bijapur and even Belgaum (lower than Bellary)

- Utilisation of health services by women is poor, and this issue is closely linked to low status of women, the lack of public health education and the glaring physical inadequacy of hospital services required by this group of users.

- The four districts of Hyderabad Karnataka region and Bijapur district in Belgaum division still have very high fertility rates. The participation of men in birth control is almost non existent.

- Lack of access to credit for women particularly from formal financial institutions has been well documented.

- Crimes against women including routine violence are heavily underreported. The police and formal legal system are clearly not seen as useful by women, for justice and redressal.

3. PRIMARY HEALTH CARE

The focus of the Task Force has been on Primary Health Care and Public Health. Primary Health Care is essential health care, universally accessible and acceptable with community participation and includes health promotion, prevention and rehabilitation and management of common diseases, at affordable cost.

Primary Health Care can succeed only with **involvement** and **empowerment of the people**. The Panchayat Raj experiment has been ushered in Karnataka to bring about **decentralised governance**. This can bring in the much needed **Community Participation** under Primary Health Care.

Primary Health Care is channelised mainly through Primary Health Centres (and the sub centres) and Community Health Centres, which are the first referral Units. A good referral system is necessary for the success of Primary Health Care. There are a large number of vacancies of laboratory technicians. Simple laboratory investigations are necessary for effective Primary Health Care.

It is recognised that the Private practitioners belonging to the different systems of Medicine are most often the first contact for health care

3.1 RURAL HEALTH

Strengthening Primary Health Centres and Sub centres

Improvement in the functioning of the Primary Health Centre is a must for Primary Health Care. Though there is sufficiency of the number of centres, according to the prescribed norms, there is need to improve the efficiency and effectiveness. There is also a need to ensure proper distribution of these centres.

Recommendations:

1. ***All vacancies of Doctors, Laboratory Technicians and ANMs must be filled up immediately.***
2. ***All key staff, including Doctors, Staff nurses / ANMs and other essential staff attached to the Primary Health Centres must stay in the quarters. Where repairs are necessary they should be carried out immediately; where there are no quarters action may be taken to construct them; if quarters are not available, houses may be taken on rent.***
3. ***The allotment for Essential Medicines (including Life Saving Medicines) must be increased by atleast Rs. 25,000/- per annum per PHC. All Essential drugs must be available at the PHC at all times.***

4. *Every PHC must have a Telephone.*
5. *Atleast 1000 PHCs in the State must be made fully functional satisfying the above criteria, within the next 6 months.*

3.2 URBAN HEALTH

Primary Health Care in Urban areas have been neglected. Urban Health is not better than Rural health, as far as the poor are concerned. Disaggregated health indicies show that often the health of the Urban poor (in the slums or scattered through the towns and cities) is often worse; the averages are better because of the health status of the affluent. There is need for comprehensive health care, especially in the slums, where the people do not have the social support which is present in the rural areas.

The Urban Family Welfare Centres and the newer health centres under IPPVIII (in Bangalore City) concentrate on Family Welfare, neglecting Primary Health Care, even though the job descriptions of the Lady Medical Officers in-charge of these centres include promotive, preventive and curative care.

Medical care at the First Contact level is provided mainly by Private Practitioners (present in relatively large numbers) and also by the Teaching and other Hospitals and Nursing Homes in the Cities and Municipalities. But this is not comprehensive Primary Health Care.

The different Health Centres within the urban areas under the Municipalities and Corporations function independently of the Directorate of Health Services. There is need for better co-ordination for efficiency and effectiveness.

Recommendations:

1. *The Urban Family Welfare Centres and Health Centres under India Population Project VIII should be involved in comprehensive Primary Health Care.*

3.3 REFERRAL SERVICES: Secondary and Tertiary Health Care

Primary Health Care requires the support of Referral Centres (Secondary and Tertiary) for its effective functioning. Primary Health Care looks after common ailments. Other conditions require more specialised care which are provided by Taluka, District,

Teaching and Speciality Hospitals. The success of Primary Health Care depends on the referral system. This should be made responsive to and responsible for the care of the referred subjects.

Recommendation:

1. ***Complete the Secondary Care Institutions in progress under KHSDP (100 Secondary Care Hospitals) in the next six months and make them fully functional with adequate Human power, equipments and accessories. The OPEC Hospital in Raichur must be made functional as early as possible. Work out effective linkages of Primary Health Care Institutions with the referral hospitals.***

3.4 EMERGENCY HEALTH SERVICES

Provision of emergency services can prove to be life saving or avoid life-long misery. Emergency services

- Provide immediate relief to patients with acute medical, surgical, obstetric or other emergencies,
- Manage accident and poisoning victims, and
- Attend to medico-legal problems.

Recommendations:

1. ***Improve the capability of the Health Care Personnel at PHC to attend to emergencies. The Emergency services should cater to all emergencies, including Obstetric and Gynaecological cases, poisoning cases and Dog and Snake bites. Polyvalent anti-Snake Venom Serum must be made available at all PHCs at all times as a life saving measure.***
2. ***Well-equipped Ambulance Vans with well-trained paramedics must be positioned on the National and State Highways to attend to accidents. Network the Trauma Centres with the Taluka / District Hospital; with adequate Communication facilities. SGARRC and NIMHANS to be the nodal Centres.***

3.5 LABORATORY SERVICES

Health care, at primary and higher levels, depends on diagnostic quality which in turn requires laboratory tests in specific instances. The tests appropriate for primary and secondary levels have been defined. Unfortunately most of the laboratories attached to the Primary Health Centres are non-functional, because of lack of trained laboratory technicians and equipments, such as Microscopes and reagents. It is essential to ensure

that every laboratory has a working oil immersion microscope, necessary glass-ware and accessories and reagents.

Recommendations:

1. ***All laboratories must be staffed with trained technical persons and equipped with the necessary instruments, accessories and reagents. Fresh appointees must be given orientation training before posting and existing staff should be given refresher training.***
2. ***The PHC laboratories must provide prompt and efficient service for the diagnosis of TB, malaria, leprosy RTI/UTI and other routine investigations must be available.***
3. ***Rs. 30,000/- per PHC to be initially earmarked for the purchase of Microscopes (about Rs. 15,000/-), equipment, glassware, other accessories and reagents.***

3.6 BLOOD BANKING AND TRANSFUSION SERVICES

The Supreme Court initiative and revision of the Drug Control Act & Rules for blood banks have sought to ensure blood safety & bring quality in Blood banking & Transfusion Services. But the sudden transition to stringent norms is a cause for concern. The lack of access to licensed blood banks especially for patients in remote & peripheral areas, has resulted in blood not being available and therefore denial of a life-saving intervention.

There is an unequal distribution of blood banks (Bangalore has 40, many districts have only one each and 8 districts do not have even one). Setting up of and licensing of new blood banks should address regional disparities.

There is an inadequate voluntary donor base. NGOs have taken a proactive role in the voluntary blood donation movement.

There is sub-optimal and irrational use of blood.

Recommendations:

1. ***The eight districts in the State which do not have a Blood bank to have atleast one blood bank each.***
2. ***A study to be initiated and concrete proposal(s) to be developed to ensure and make available safe blood to the needy in the districts. The proposal to also review the existing guidelines and their feasibility. A representation to be made by the State Government to the Government of India in this regard.***

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

1. Possibility of having doctors of ISM&H to be incharge of some of the PHUs.
2. Having some selected and willing NGOs to manage the PHCs.
3. Improving the linkages of Primary Health Care Institutions with Secondary and Tertiary care institutions.
4. Study the organisation of Urban Primary Health Care under Corporations and Municipalities and Integration / Co-ordination with the Directorate of Health and Family Welfare Services.
5. Quality Control of Diagnostic Laboratories.
6. All Health Care Institutions PHCs and above to have **Health Advisory Committee**, including representatives of VOs and representatives of Health Professional bodies (other than the Board of Visitors).
7. Working hours of the Health Care Institutions to suit community needs.
8. User fees and their utilisation.
9. Setting acceptable standards for Primary Health Centres, Community Health Centres and other Health Care Institutions.
10. Training in First Aid and Cardio-pulmonary Resuscitation.
11. A comprehensive plan to motivate and mobilize voluntary blood donors to ensure adequate supply of safe blood throughout the year and all over the State should be developed with the help of NGOs.
12. The medical community should be sensitized to make optimal & rational use of blood. Every hospital should have a blood transfusion committee to ensure this.
13. Pilot projects to study the logistics management and monitoring of the 3-tier system of - Component Center-District blood bank-blood storage unit should be initiated.
14. Establishing Zonal Blood Component Separation Centres.
15. **Round-the-clock Services** at PHCs with resident Lady Medical Officers.

4. PUBLIC HEALTH

Public Health is the Health of the Population, achieved by improved life style, good nutrition, water supply and sanitation, maintenance and improvement of the environment and reduction and removal of risk or causative factors of diseases and an appropriate and immediate intervention, should there be an outbreak of the disease.

The government has accepted the responsibility to take measures to improve the health and well being of its citizens through the Constitution and various Policy measures. Amongst the sub divisions of Public health are:

- Nutrition
- Drinking water supply
- Sanitation and Waste Management
- Communicable Diseases
- Non-communicable Diseases

The State government adopted the strategy of providing the Basic Health Services through the Health Centre concept, providing comprehensive preventive, and curative services. Promotive and rehabilitative services which are an integral part of Comprehensive Health Care have not yet been adequately addressed.

4.1 STRENGTHENING THE PUBLIC HEALTH SYSTEM

Human Resources for Public Health

A major drawback noticed by the Task Force was the lack of public health qualifications and expertise among staff managing public health programmes at State, district and taluka levels. Promotions, too, are based on seniority and not on competence for the task. There are mismatches between personal qualifications and the job. For instance a gynaecologist may be a District Malaria Officer, or a surgeon a District Health Officer. Public Health is mistakenly perceived to be administration which supposedly any doctor is capable of carrying out. It is essential that the persons appointed to carry out Public Health activities have the necessary expertise and experience.

Recommendations:

1. ***A Short two-week course on Public Health principles and practice for Taluka and District Health Officers at the State Institute for Health and Family Welfare. Short in-service orientation courses on public health principles and programmes for PHC Medical Officers to be run by the State Institute in collaboration with District Training Centres.***

Structural Issues in the Public Health System

Integrated approaches

For historical reasons a number of vertical national health programmes were developed to address major public health problems. Each developed their own systems of service delivery, recording, reporting, supervisory control and resource generation. In the 1960s, the Ministry and Department of Health were split into two, for health and family welfare respectively. These factors have resulted in a fragmentation and compartmentalisation of the health system, with duplication of reporting systems. Though the Kartar Singh Committee in the 1970s recommended integration, this has not occurred in spirit or in action. There are still multiple sources of funding and of systems. Referral systems too are still ineffective.

Recommendations:

1. ***A review of the Externally Aided Projects to be initiated to facilitate their absorption into the Health System. Sustainability and consolidating the gains / achievements to be the primary objective.***

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

1. Qualifications in Public Health to be a requirement for Taluka, District, Divisional and State level Health Officers of public health programmes.
2. Health Administration and Management courses for senior health staff.
3. All public health posts to be made full-time posts without private practice. A suitable allowance equal to one third of basic pay to be given. For good comprehensive care, including public health care at the Primary Health Centre level, it is necessary for Primary Health Centre medical officers to also be full-time with adequate compensation.
4. State level posts for public health programmes to be filled by selection, based on qualification and competence, and not by promotion on seniority alone.
5. Health manpower planning policies to develop people for senior selection posts.
6. Medical colleges in the State to be made partners in the public health training of government staff.
7. Evolve a comprehensive health policy.
8. Integration of the departments of Health and Family Welfare.
9. Evolve mechanisms to strengthen integrated functioning of health personnel, even though they are paid under different programme heads.
10. The referral system to be improved on a district-wide basis and to be renewed annually, with indicators to be developed.

11. The Department of Health and Family Welfare to collaborate with the Ministry of Rural Development and Panchayat Raj, Urban Development and with the Institute for Social and Economic Change and NGOs to
    - Develop training modules on water supply, sanitation and health for elected local body members.
    - Organise Training of Trainers on Panchayat Raj and Health for all districts.
    - Create IEC materials for the general public on the public health powers and functions of local bodies. Wide dissemination of this information through mass media.
12. Special training for building community capacity regarding Panchayat Raj and Health, including microplanning, for NGOs, CBOs and leaders of community groups such as Mahila Sanghas, Yuva Sanghas etc.
13. The role of Public Health Institute, Bangalore and State Surveillance Centre, Bangalore

4.2 NUTRITION

An issue of concern is the continuing high prevalence of mild to moderate malnutrition among all segments of the population. Under-nutrition affects the growth and development of the child and the health of all at every age.

Exclusively breast fed infants grow optimally till about 5 months and upon weaning slacken for weight and height gains in comparison to the nationally accepted norms. At 6 months, about 15% infants are underweight for age and this proportion rises to 65% by 4 years. Although the prevalence of severe malnutrition in the community is low, the high prevalence of mild and moderate undernutrition and micronutrient deficiencies, particularly that of Vitamin A and iron, are of serious concern. Such undernutrition has long term deleterious consequences for physical and intellectual growth and development. Girls who have gone through this path tend to give birth to low birth weight babies, thus perpetuating this adverse cycle.

Undernutrition predisposes to increased severity and increased case fatality of common infectious diseases including measles, gastroenteritis and lower respiratory tract infection. In summary, **ensuring optimal nutrition** during infancy, preschool age, school age and adolescence **is one of the most crucial determinants of the survival, health, growth and development of individuals** in the community. The provision of food and ensuring food and nutrition security and just distribution of food are concerns of the Health Sector. One of the defects that requires remedy is the relatively high price of pulses and oils. For the not-rich population, pulses and oil are the main source of protein and fat respectively; their deficiencies are the major reason for calorie deficiency and undernutrition in general. The Government must take a broad view of

these issues and ensure effective and coordinated action to fulfill the nutritional security of growing children and adolescents. The Health Sector must give critical support in defining nutritional norms, defining and monitoring norms of nutrition and growth, and in providing health education.

Recommendations

1. *Define and establish the items of coordination between the Health Sector and ICDS. These must include*
   - *(a) A mechanism to detect, take corrective steps and monitor children with mild to moderate undernutrition,*
   - *(b) Coordination in detecting and treating infectious diseases in children, especially diarrhea skin and ear infections with appropriate care.*
2. *Weaning foods for Infants and children above Six months to be made available under the ICDS scheme.*
3. *Systematic promotion of kitchen gardens supported by seed/seedling supply. Drumstick, Chakramuni (Chikermane), Amaranthus, Papaya, local beans, are some examples.*
4. *Upgrade the post of Deputy Director of Nutrition (Dept. of Health) to Joint Director and expand the role and job description of the JD to fulfill the responsibilities and implement and monitor the Nutrition programmes.*

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

1. Education of mothers, health check ups of children and training to Anganwadi teachers regarding Nutrition and Health.
2. Increase supplementary food supply to pregnant women.
3. Create avenues of Nutrition education and awareness creation to all, in particular to women.
4. Encourage and popularize nutrition mixes for supplementation. Locally available and familiar food grains (eg. Ragi), pulses, millets, cereals, ground nut, jaggery and vegetable oils should be used. These may be home mixed, or locally produced as projects under Mahila Mandal etc. CFTRI advice to be sought.
5. Enhance the production of Ragi, Jowar and Pulses and their distribution through the Public Distribution System.

4.3 WATER SUPPLY AND SANITATION

The **second most crucial determinant of health** (by way of absence of disease), conservation of nutrition (due to prevention of disease) and prevention of undernutrition (by way of avoiding the negative energy/nitrogen balance of illness), **is**

the provision of adequate safe drinking water and sanitation to prevent pathogen contamination of the environment by avoiding fly menace and mosquito breeding. The environment, especially water, may act as a vehicle for chemical toxins. Northern Karnataka has the recognized problem of bone fluorosis, a debilitating disease due to excess fluoride in well water. Unless specifically tested for, we may not even know about some toxins (eg. Insecticides, arsenic etc.) The Health Sector must define norms, develop monitoring techniques and processes and apply them in all communities. The Government must evolve a coordination mechanism to ensure regular and routine monitoring and ensuring corrective steps when deficiencies are detected.

Sewerage systems and measures for environmental sanitation are very inadequate particularly for the rural population and the urban poor.

Recommendations

1. ***Ensure regular water quality testing facilities in all the districts. The monitoring to be facilitated and coordinated by the District Surveillance Units. The PHC and Taluka Medical Officers should visit all sources of drinking water periodically.***

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

1. Mechanisms for intersectoral co-ordination between Ministeries/departments for rural and urban development, water supply and sewerage boards, and pollution control boards.
2. Gram Panchayats and Municipal Bodies to be activated regarding their responsibilities and powers for provision of water supply and sanitation.

4.4 WASTE MANAGEMENT

Solid Waste Management has been receiving greater attention in the recent past. With the signing of the International Treaty banning the import of hazardous waste into the country, there has been accelerated efforts towards safer waste management practices. Three waste streams have been identified for better management. They are Industrial hazardous waste, Bio-medical Waste and General Municipal Solid Waste.

The Centrally promulgated Environment Protection Act, 1986 and rules therein (Hazardous Waste (handling and management); Biomedical Waste (handling and management) and Municipal Solid Waste (handling and management)) currently govern the waste management practices.

Enlightened citizens coupled with Judicial activism have ensured that due attention is paid towards this neglected issue. While Management of Municipal Solid Waste is an obligatory function of the Municipalities and the local governments, the principle of Polluter pays with the onus of responsibility on the generator for safe management holds true of the other special categories of waste.

The State of Karnataka has been leading in terms of activities towards safe management of waste especially the Solid Waste and Health Care Waste. Community Based Organisations and Neighbourhood groups have been leading the endeavours. The Bangalore Agenda Task Force has set for itself Night Collection of Garbage, Door to door collections of Household waste, Dumping Yard, modernisation of transport vehicles.

Efforts are currently on to implement systems for safe management of health care waste in all the secondary care hospitals under KHSDPas also by private, voluntary and corporate hospitals. The concern of environmental pollution because of each and every institution attempting an incinerator system is being addressed. The solutions have been towards common health care waste management facilities.

Co-operative endeavours need to be proactively encouraged. The Problems related to Waste Management are as follows:

- Lack of an efficient link and co-operation between the elected and assigned body
- Multiple departments with different responsibilities towards SOLID WASTE MANAGEMENT
- Lack of comprehensive policy and long-term planning
- Lack of appropriate trained staff in management and planning

Recommendations

1. ***Ensure proper segregation of Waste and total waste management at all health care institutions.***
2. ***All health care institutions including Primary Health Centres and General Practitioners Clinic, should develop a policy and action plan for safe management of waste generated in their premises. The segregated waste streams should not get mixed up with general solid waste.***
3. ***Initiate orientation and training of Health Care Personnel for proper waste management practices including practice of Universal Precautions.***
4. ***The government should support initiatives for common waste management treatment facilities.***
5. ***A Sanitary Landfill site must be identified for all Towns and Cities by local bodies, with assistance of the Health Department.***

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

1. Incorporating aspects of Safe Management of Health Care Waste into the curriculum for all health sciences
2. Safe Management of Health Care Waste to be incorporated into the training courses at the State Institute of Health and Family Welfare and the District Health and Family Welfare training Centres
3. An Action Plan for an integrated waste Management plan which incorporates Segregation as a primary component and includes strategies for Health Care Waste to be developed in partnership with the Stakeholders and the Neighbourhood groups.
4. Health Impact Assessment to be part and parcel of Environment Impact Assessment for all Industrial Projects.

4.5 COMMUNICABLE DISEASES

Due to their importance in affecting the health of the people and causing death, disease and disability several national programmes have been established to control, eliminate or eradicate specific Infectious Diseases, namely National Leprosy Eradication, National Tuberculosis Control, National Anti-malaria, National Filaria Control and National HIV / AIDS Control, National Guinea worm Eradication and National Polio Eradication. In addition, the National Immunisation Programme aims to control the cluster of diseases together called **vaccine preventable**. The burden of infectious diseases does not seem to be declining satisfactorily, inspite of our efforts.

A number of Infectious Diseases that were at one time very common in developed countries but were controlled by the systematic application of public health principles, actions and interventions, are still prevalent in Karnataka. They include *faecal-oral transmitted* via water or food (cholera, typhoid fever, dysentery, hepatitis A, E*), vector borne* (Malaria, Filariasis, Japanese Encephalitis, Dengue Fever), *animal to human transmitted* (Rabies, Brucellosis, Leptospirosis, Cysticercosis), and person to *person* transmitted (tuberculosis, sexually transmitted diseases). We have not been able to eliminate or even control them, either due to *non-application of public health principles or actions,* or in spite of disease specific *control programs*, which are *not being applied efficiently*.

On top of this burden, new (emerging) or resurgent Infectious Diseases are also posing a threat to the health of the people. The most important among them is HIV / AIDS, which appeared first in 1987-88 and since then it has been slowly but relentlessly spreading.

The occurrence (prevalence) of an exogenously transmitted Infectious Diseases such as cholera, typhoid fever, malaria is already evidence for the silent phenomena of huge numbers of the microbial pathogens (amplification) and of patent pathways of transmission. The occurrence of at least one more epidemiologically linked case is warning that an outbreak is potentially in the making. Immediate actions (to diagnose the infection and the transmission pathway, and to prevent further transmission) are necessary to prevent a larger outbreak. This requires a dynamic *disease surveillance system*, the *infrastructure to investigate (microbiologically and epidemiologically)* and the *skills to define, design, apply and evaluate specific interventions* successfully. Such system / infrastructure, essential for public health, is absent in Karnataka.

4.5.1 Vector Borne Diseases

The heavy burden of **malaria** could be noted from the documented numbers of cases in Karnataka. In 1997, under the government health system 7,304,866 fever cases were tested with blood smear microscopy and 161,775 cases of malaria (including 39,877 *P.falciparum*) were diagnosed. In addition, in 8 urban populations 103,671 fever cases were tested in 1997 and 12,548 cases (382 *Pf*) were detected. In 1988 the numbers of malaria detected were, rural 107,910 (23,469 *Pf*) plus, urban 7,521 (598 *Pf*). Malaria is not under control and unlike in the past, it is prevalent in urban populations as well as in rural populations.

Kyasanur forest disease is peculiar to Karnataka (Shivmoga, Uttara and Dakshina Kannada, Chikmagalur). Other vector borne viral diseases include Japanese encephalitis (JE), dengue fever and dengue haemorrhagic fever / shock syndrome (DHF/DSS) and West Nile virus disease. During 1999, outbreaks of JE were confirmed by laboratory confirmation of cases in the districts of Bellary, Raichur, and Kolar. JE is known to occur in the districts of Chitradurga, Koppal, Mandya, Bangalore urban and rural. In 1997 there was a large outbreak of DF and DHF / DSS in Bangalore urban and rural and Kolar. In the same year DHF / DSS became recognized by the public on account of the media attention of an outbreak in Delhi.

4.5.2 Tuberculosis

In 1998 the estimated target for new TB cases to be detected in Karnataka was 70,284 but the achievement was only 55,557 (79%). Even this figure might be an overestimate since the number of sputum smears examined was only 236,175 (30%) against a target of 782,172. In 1999 first quarter, the achievements were even lower with 11% sputum examination and 26% case detection.

4.5.3 Immunisation

The reported achievements of childhood immunizations in 1997-98 have been above 100% for BCG, DPT, and OPV: for measles vaccine it was 94%, the TT coverage for

pregnant women was also over 100%. However in the absence of a disease surveillance system, combining information from govt. sector and private sector health care systems, the degree of reduction of vaccine preventable diseases cannot be ascertained. Alternate independent information indicates that the achievement in childhood immunization in Karnataka is below 80%.

4.5.4 Food and Water Borne Diseases

Karnataka is endemic for cholera / gastroenteritis, with annual seasonal increases around monsoons. Indeed 'cholera combat teams' have been established and located in Gulbarga, Bijapur, Chitradurga, Bellary and Mysore districts. During 1998, 501 deaths due to gastroenteritis and 2 deaths due to cholera were documented. The number of reported cases of acute viral hepatitis was 2520 (2 deaths) and typhoid fever 842 (4 deaths). The above statistics are based on information received from within the government health care institutions.

4.5.5 Worm infestations

The two principal Helminthic infestations are Round Worm and Hook worm. Their burden and the impact on health are largely underreported. Their contributions in accelerating malnutrition (PEM and Nutritional anaemia) is well documented. The Primary Prevention methods have been successful whenever implemented in full. There is thus an urgent requirement to provide for Safe Drinking water, Sanitary disposal of human excreta and health education for better personal hygiene and use of latrines

4.5.6 HIV/AIDS

The Human Immunodeficiency Virus (HIV) and cnsequent disease of AIDS have been slowly but steadly speeding in Karnataka since the late 1980's. The predominant mosde of transmission is multi partner heterosexual contact. After the intorduction of Blood safety measures, spread through unscreened transfusion has declined markedly. Currently, the main concern is the spread of HIV infection to mongamously married women who get infected from their promiscuous husbands. Mother to infant (vertical) transmission is now being recognised. The National AIDS Control Organisation and the Karnataka AIDS Control Society have been mainly responsible for data collection and programme planning and implementation.

The age spectrum of HIV infection is another cause for concern. Youth are increasingly seen to be infected. Future interventions need to be addressed at enabling youth to adopt safe behaviour with regards to STI and HIV.

4.5.6 Other Infectious Disease

There are a number of other infectious diseases which affect our people, but they do not get attention from the system. For example Acute respiratory infections including pneumonia (1,912,650 episodes and 215 deaths reported in 1993), rabies (40 deaths in 1990, 34 deaths in 1993) sexually transmitted diseases (11,949 cases of syphilis and gonorrhea in 1995). Acute rheumatic fever and chronic rheumatic heart disease are important causes of disability and premature death. The frequency of bacterial meningitis, leptospirosis, Brucellosis, Rickettsial fevers, melioidosis remain unrecognized. The extent, nature and pattern of hospital acquired *(nosocomial)* Infectious Diseases remain largely unrecognized. *Antimicrobial sensitivity and resistance patterns* of major infectious agents are tested in many institutions, but such information and data are not *monitored constantly and the responses and remedial measures* developed and applied are not evaluated.

It is evident that the several of the *National Health Programmes* are either not succeeding or are actually faltering. Each programme deserves to be *evaluated and remedial measures identified and applied.* In this context, the State must take the lead and initiate to undertake the endeavour to identify and suggest the remedial measures.

Recommendations

1. ***Sputum (TB) and blood smear (Malaria) results on every sample to be reported within 24 hours of specimen collection; 5% random sample check by supervisory staff. Induction Training and Refresher course of Laboratory technicians by rotation.***
2. ***One Day Workshop each for Tuberculosis and Malaria to help the rational implementation and vitalise the TB control and Anti-malaria programmes in the state. The participants to include State and District Officers and all Professors of Medicine of all Medical Colleges in the State and representatives of all relevant Professional Associations.***
3. ***Choose one model of Communicable Disease surveillance (in contra-distinction to HMIS) after considering the model developed by KHSDP.***
4. ***Every school must have facilities for Safe drinking water and latrines. Proper use of latrines must be inculcated at the school level itself.***
5. ***Periodic deworming and correction of the Nutritional anaemia (by providing supplementary Iron tablets) for pregnant and lactating mothers, women, children and adults.***

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

1. Make all Taluka and District Hospitals fully functional to diagnose and manage all communicable diseases.
2. Malaria and other Vector Borne Diseases: Review the VCRC Recommendations for Bangalore City and follow up for implementation.
3. A comprehensive action plan to be prepared within 6 months for Rabies control. Train relevant personnel on rational use of Anti-Rabies Vaccine. Ensure strict licensing and immunizing of pet animals in every town and / or city. Public education is urgent.
4. Establish one Integrated model of Disease Surveillance after examining the KHSDP Model
5. Develop a proper training system for Taluka Health Officers
6. Computerise every District Health Office and later Taluka Health Officers for Disease surveillance.
7. Every house must have a mechanism for sanitary disposal of excreta
8. Study the logistics for newer Vaccinces for children

4.6 NON-COMMUNICABLE DISEASES

Non-communicable diseases form a large group. Most of them do not have a cure but we can alleviate pain and suffering by judicious management.

There is a constant increase in the incidence of non-communicable diseases: longer life span unhealthy life styles, increasing stress and strain-all lead to increased incidence.

Amongst the diseases to be tackled include diabetes mellitus, hypertensioncardio-vascular dieseases and cancer (such as cervical, lung, oral, gastro-intestinal). Others include goitre or other thyroid disorders, diseases of the lung including asthma and chronic obstructive pulmonary disease.

4.6.1 Diabetes mellitus

The incidence of diabetes is on the increase. Even taking the incidence as low as one percent, Karnataka will have as many as five lakh people, suffering from the disease and its complications leading to kidney, eye and other problems. The disease has to be detected early to prevent complications.

The State does not have a well-recognised centre to educate, guide and manage the people problem. Very few the medical colleges have this speciality developed to any extent.

Recommendations

1. *All PHCs to have facilities to detect and manage / refer patients with Diabetes*
2. *Secondary Care hospitals should have physicians re-oriented for the management of persons with diabetes and their complications together with the needed anti-diabetic drugs, including insulin.*

4.6.2 Hypertension and Cardio-vascular Diseases

The incidence of high blood pressure is high. It may occur along with diabetes. Hypertension can cause various complications such as heart disease, kidney disorders, etc.

Ischaemic Heart Disease is a leading cause of death. Atherosclerosis is the underlying cause of most of Ishcaemic cardiac events . It can result in Myocardial Infarction, Congestive Cardiac Failure, Cardiac Arrythmias and sudden Cardiac death. The Risk increases with age, smoking, hypertension, diabetes and high cholesterol.

Recommendation

1. *All PHCs to diagnose hypertension and risk factors for Cardio-vascular diseases and manage / refer patients as necessary.*

4.6.3 Mental Health and Epilepsy

Mental health problems are increasingly being recognised as manageable. Persons with mental illness can be treated effectively and they can lead a productive life in the society.

Mental health problems include psychotic problems, depressive disorders, alcohol related problems (medical and neurological, accidents and sociological) and neurotic stress related and adjustment problems. People attending the outpatients often have somatoform disorders and suffer from subjective distress; they come with multiple, vague symptoms.

While the majority of the persons with mental illness can be managed at the primary health care level, there is also need for specialised departments and institutions. **Karnataka Institute of Mental Health, Dharwad** is the only State government run mental hospital. Even this has now become a part of the Karnataka Institute of Medical Sciences. The conditions there are poor. It is necessary to maintain the Institute of Mental health as a major State speciality Hospital. Its structure and functioning need considerable improvement. The Task Force awaits the report of the review committee set for up for this purpose. The other major institution is the

National Institute of Mental Health and Neurosciences, Bangalore. This is an autonomous institution and is doing very good work. A good proportion of the patients is from the State.

The departments of Psychiatry in the Medical Colleges are very weak, with the exception of two or three private medical colleges.

Epilepsy is more common than thought of and can be managed effectively. Hot water epilepsy is very common in Mysore plateau region and needs special attention. Early diagnosis based on clinical methods and regular treatment by Primary Care Physicians using inexpensive drugs like Phenobarbitone and Phenytoin can effectively control epilepsy. What is required is the need to ensure supply of medicines without break.

Recommendations

1. ***The Community based Mental Health Programme in Bellary District should be strenghtened.***
2. ***Train Primary Care physicians and paramedical workers in the diagnosis and management of epilepsy. Make available the needed drugs (phenobarbitone and phenytoin) without break, through the Primary Health Centres.***
3. ***Improve the facilities and conditions in the Karnataka Institute of Mental Health, Dharwad, which should continue as the major speciality institute with autonomy in governance.***

4.6.4 Cancer Control

With the increase in Life expectancy, Cancer is becoming a major Public Health problem. Cancers are said to be the 3rd major cause of death in India. Nearly 45,000 new cases of cancer are detected in Karnataka every year. It is estimated that the Prevalence is about 1.5 to 2 lakh cases.

The higher incidence of cancer in female is due to the greater proportion of Cancer Cervix and Breast cancer. With the increasing trend of using Tobacco in the form of smoking and Gutka especially by men, oral, oesophageal and lung cancers are more commonly encountered.

There is a need for looking into the magnitude of the problem of cancer in Karnataka in a broader perspective of utilisation of existing and available facilities. A combination of lack of awareness, economic condition, fear of disease, inadequate diagnostic facility has resulted in presentation of these cancers in advanced stages.

At present only 1/3 of the Cancer cases are being treated in the different facilities. There is a need to establish more Cancer treatment facilities with low cost, high quality care. Involvement of the Non-governmental agencies is very crucial.

Recommendations:

1. ***Downstaging of Cancer Cervix programme to be initiated on priority.***
2. ***A model comprehensive Cancer Control Pilot Project to be initiated at Mandya district.***
3. ***Director, Kidwai Memorial Institute of Oncology, Bangalore to be ex-officio Joint Director (Cancer Control)***

4.6.5 ORAL HEALTH

Dental caries, poor peri-odontal health and oral cancer are common in Karnataka. It is necessary to tackle them for improved health. There are dental clinics in the district and many of the taluka headquarters.
Community Dental Health Programmes can improve dental health

There are belts of fluoride in drinking water in many districts. These affect the teeth in addition to the bones.

Recommendations

1. ***All Taluka hospitals to have qualified dental surgeons.***
2. ***Principal, Government Dental College to be ex-officio Joint Director (Dental Health)***

4.6.6 OCCUPATIONAL HEALTH

Every occupation carries with it inherent health hazards. In addition, accidents occur. These add on to the other common health problems. The occupational health hazards can be controlled.

The largest number of persons are involved in **agriculture**. There is increased use of pesticides to protect the crops. All pesticides are poisonous. With the pests developing resistance, the dose of pesticides and the harmful effects increase, affecting the workers directly and indirectly, in the factory and the field. There are pesticide residues in the food chain, water and soil affecting all the people.

Agricultural workers are often affected by ergonomic problems in the use of tools. Exposure to biological agents add to the adverse effects.

Sericulture is the source of employment for a large number of people in the State. Karnataka is the leading producer of silk in the country. Allergic manifestations such as breathing problems and skin disorders are common in those involved in the industry.

Beedi industry involves large numbers of men, women and children. The tobacco contained in the beedi affects their health

Silicosis is common in the workers in the granite and related industries

Many people are involved in **Poultry** rearing. It has a number of health hazards.

There are many large, medium and small factories in manufacture and fabrication. Many chemicals like Lead, Zinc, Nickel, Cadmium and Chromium are involved. Many of these industries also produce high levels of noise, which can affect hearing.

There are many laws designed to reduce occupational health hazards but they are seldom used effectively.

Karnataka has the Regional Occupational Health Centre of the Indian Council of Medical Research. Its services must be used more effectively to reduce the occupational health problems.

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

1. Health Education to improve Life style, physical exercise and food habits.
2. Health education to avoid risk factors for primary and secondary prevention of Hypertension and Ischaemic Heart Disease
3. All doctors must be able to tackle high blood pressure and prevent its complications and to provide immediate care in cases of Ischaemic heart disease and refer as necessary.
4. Sensitise the primary care doctors (PHC doctors and private practitioners) to mental health problems and issues, and develop a district programmes based on the learning experience at Bellary District Programme.
5. A Joint Director at the State level may be given the duties to co-ordinate and improve mental health activities. A comprehensive Mental Health Programme for the State to be developed.
6. Strengthen the facilities for psychiatric service and training in the teaching hospitals.
7. The Karnataka State Cancer Control Advisory Board to be reactivated and made the nodal agency for linking the Cancer treatment centres across the state
8. Initiating a rural cancer registry on a Pilot basis

9. Proactive discouragement of Tobacco company advertisements and sponsorships.
10. Banning the sale of Tobacco in any form within 100 metres of school premises and Banning its use in Office Premises and Public Places
11. Shifting the cultivation of the cash crop of tobacco to food or other crops.
12. Health education for better dental care and reduction of tobacco chewing.
13. Specialist services (Orthodontics and Maxillo-facial services) at district level.
14. Promote Community Dental Programmes with involvement of Dental Colleges.
15. Effective enforcement of the laws controlling pollutants and safety in industries.
16. Periodical health check-up of the workers and follow–up.

5. MATERNAL AND CHILD HEALTH

Shortfalls in staffing requirements, especially lady medical officers and trained birth attendants has lead to sub-optimal implementation of RCH programs.

The aim of the RCH program to attain 100% institutional deliveries may be a laudable one. But the "institutions" are inadequate in numbers and in terms of infrastructure. ANMs too are not always available. So the proportion of institutional deliveries is low. **In this context the role of the Traditional Birth Attendants or Dais is very crucial in providing delivery services**. It was surprising to note therefore, that the Dai training program was abruptly stopped without ensuring functional alternatives. The **Disposable Delivery Kit program** also has been abandoned by the Central Government without insights into its functioning or the need for alternate measures.

During delivery, while the birth attendant looks after the mother, including the expulsion of the placenta, **meeting the essential needs of the newborn is inadequate**. If the baby does not breathe within 60 seconds, immediate external assistance will be essential to prevent asphyxia. The throat has to be cleared of secretions by simple suction and the baby may need physical stimulation to start breathing and prevent brain damage. These simple measures may make all the difference. Other common complications like hypothermia and feeding problems, especially in low birth weight babies, are likely to lead to death unless promptly recognised and remedied. All these skills can be taught to any intelligent adult woman, especially if she is motivated. She can also be trained to recognise sepsis (including pneumonia and meningitis) by simple criteria. We can reduce neonatal mortality, which currently conrtributes about half of the infant mortality, then we can drastically reduce our IMR. It is currently a matter of concern that the Infant Mortality Rate has become 58 per 1000 live births in 1998, while it was 53 in 1997 and 1996.

Exclusive breast feeding of the infant till 4 to 6 months is very important to maintain the nutrition and growth of the baby and to prevent diarrheal diseases. Infants tend to falter in the rate of weight gain from the time of **weaning**. This is due more to the lack of understanding of Nutrition than the lack of food items in the household. The worker involved with the prevention of Neonatal Mortality could also be entrusted with assissting mothers with Breast feeding and proper weaning as well as **Growth Monitoring** to detect any deviation from the normal pattern. The same worker could oversee the full immunisation of the infant. Such a Village level worker, if present in a population of 1000 people, will have to supervise the birth and growth of approximately 20 babies per annum. The Anganwadi provides the necessary food items for weaning as well as Nutritional Supplementation of Preschool Children. The suggested worker would concentrate in the first year of life.

People are not aware of the facilities that are available for Maternal and Child Health. Corruption is present at many levels. Money is demanded even when the delivery is supposed to be free. Unaccounted charges are collected even from the poorest. These are

general issues and are more relevant to delivery of MCH services, especially when we understand that nearly 65% of our population is women and children.

The **quality of services is poor** due to a lack of discipline, accountability and motivation among the health care givers at all levels. Often even the basic common courtesies are not extended. A telling evidence is the treatment meted out to the women at tubectomy camps, where numbers score over the entitlement of the people. There is also a need for ensuring the availability of medicines (example: IFA tablets) at all times especially when the proportion of Nutritional anaemia is 80%.

People are not necessarily aware of the facilities that are potentially available for Maternal and Child Health. Corruption is present at many levels. Money is demanded even when the delivery care is to be free of charge. Unaccounted charges are collected even from the poorest. These are general issues and are more relevant to the provision of MCH services, especially when we understand that nearly 65% of our population are women and children.

Recommendations

1. ***Increasing the skills of ANMs in the CNA methodology. Revision of the existing training syllabus to incorporate enhanced technical and communication skills. Sensitisation regarding the importance of the timing, spacing and number of births and exclusive breast feeding for the first 6 months.***
2. ***The role of Dais in safe deliveries should be supported and training enhanced. Disposable Delivery Kits of good quality and cost effective components should be provided.***
3. ***Where services of ANM are not available, the Anganwadi Worker to be trained to undertake the specified activities till a regular ANM is posted.***
4. ***To cater to the Newborn Care the Anganwadi worker to be trained to be the second functionary. She may be given additional monetary compensation.***
5. ***Ensure 100% registration in the first trimester, proper antenatal, natal, and postnatal care with involvement of Private sector.***
6. ***Ensure uninterupted supply of IFA at all times at all Health Care Institutions.***
7. ***Ensure 24-hour delivery services at FRUs with involvement of Private sector.***
8. ***A Pilot Project has been taken up in the district of Bellary with proactive involvement of FOGSI. The identified FOGSI members would undertake Antenatal Clinics for those at high risk within a radius of 10 Kms from the FRUs, complement the available services in Public Hospitals and also involve in Training programs.***

ISSUES AND CONCERNS FOR MEDIUM AND LONGTERM CONSIDERATION

1. Enhance the Mobility of the ANMs. The loan facility to buy a two wheeler may be made available in districts not covered by India Population Project IX.
2. Accessibility to FRUs for the people may be ensured by supporting the community funds for emergency transportation.
3. Health Education and Information programs should be systematised. Child care programs, and immunisations can be promoted with the help of the private sector (eg. Indian Paediatric Association).
4. The camp methodology for sterilisation operations should be discontinued. Instead the availability of sterile, hygienic conditions for carrying out the surgical procedures eg. sterilisations, MTPs etc on specified days (Fixed-Day strategy) should be ensured at the Health Care Institutions, which are equipped for this purpose.
5. Provision of cluster services for women and children in one place and at specified times will ensure better utility of the services. Eg. Nutritional programs, Health Education, self-help group meetings, Immunization, etc in anganwadi premises.
6. Integration of RCH programme into the General Health Care Delivery.
7. Procurement / supply of IFA tablets, Vaccines to be reviewed and streamlined.
8. Based on the experience at the Bellary PCH Pilot Project, FOGSI Initiative to be extended to other Districts.

6. POPULATION STABILISATION

In the recently announced National Population Policy 2000, it is explicitly stated that the stabilising of population is an essential requirement for promoting sustainable development with equitable distribution but this has to be within the context of enhancing outreach of primary education, enhancing essential amenities such as sanitation, drinking water, health care, employment and empowerment of women. This policy would be implemented through the States and it would, therefore, be necessary to consider the mechanisms of doing so and the elements that are of particular importance to Karnataka. It would be relevant to note that the implementation of the population policy would not be the sole responsibility of the Health and Family Welfare Department and that considerable inter-sectoral coordination is necessary.

The broad objectives of the State Policy for Stabilisation of Population would be to achieve the replacement level by 2010. While the latter could be described as attaining a Net Reproduction Rate of One (NRR=1) by that year, it would conceptually be easier to define stabilisation as attaining a Total Fertility Rate of 2.1 (TFR). The adoption of a goal of TFR of 2.1 by 2010 would be consistent with the methodology adopted by the Registrar General of India in arriving at the Population projections for the country and for the State.

The projections made by the RGI, assuming a TFR of 2.1 being the desirable goal (in substitution of the concept of NRR of 1 previously adopted), for Karnataka indicate that the State would attain replacement level in 2009. The population of Karnataka in the years ahead would be as follows:-

Year (as on 1st March)	Population (000s)
2001	52,720
2006	56,181
2011	59,615
2016	62,783

The Crude Birth Rate of the State in 1996-2001 is 20.77 and is estimated to be 19.08 by 2006-11. The issue would be the implementation of family planning along with development variables in order to achieve the CBR by 2006-2011. The fall in the BR would be critically dependent on meeting the unmet need for contraception services and efficiency of the IEC and delivery systems. There is an unmet need for family planning services.

The IMR would still be comparatively high – this would imply enhancement in measures for its reduction.

The proportion in the older age groups would increase – the package of health services, including geriatric care, would need to be periodically reviewed.

Elements of a State Policy –

- Need to recognise regional disparities and need for regional / district focus with necessary variations in emphasis depending on such disparities. The parameters would include those that relate to health, RCH, the education and social sectors. Such an analysis would guide decisions regarding location and scale of health services
- Identify the important parameters and indices for that could guide such a state policy;
- Suggest any structural changes in the Department with regard to services delivery, IEC by region (being looked at separately);
- Part of the health package – but it would be necessary to recognise the need for continued emphasis on family planning – would include encouraging spacing methods, offering alternatives, combined with RCH;
- Availability, Accessibility, Quality and, if charges are levied, Affordability, of services;
- Role of Panchayat Raj institutions

Recommendations:

1. ***A Population Policy as part of the comprehensive Health Policy will be drafted for wider discussions for eliciting public and professional opinion.***
2. ***Commence a strong IEC Programme regarding the health hazards and social ills of early marriages, the need to raise the age at marriage and advantages of postponing the second child.***

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

1. Set up a Cabinet Committee which would review health services in general and the elements of the Population – and Health – Policy periodically. This should be an Empowered Committee whose decisions would be final and not need further consideration internally within the Departments
2. Consider legislation with regard to registration of marriages – as part of the attempt to prevent child marriages.

7. FOCUS ON SPECIAL GROUPS

7.1 WOMEN AND HEALTH

Poverty coupled with **Gender bias** and poor social and economic status of girls and women limits their access to education, good nutrition as well as money to pay for health care and family planning services. Early childbearing, frequent pregnancies, unsafe abortion, RTI & STI etc. contributes to the poor health of women. **Women's empowerment** therefore remains the single most important tool in bridging this gap between Services available and the user.

Work outside the home places an additional demand on the women who are already burdened with household work; reproduction and child rearing; and family demands- both physical and mental. Wage earning empowers women in decision making, but non –wage earners do not have this advantage and their contribution is not even recognized.

The nutritional status of the women is lower and starts with discriminatory trends from early infancy, through childhood and adolescence and adult life. The woman herself is partly responsible for this. She considers her nutritional and health needs as the last priority and does not know the importance of her own health as a contributing factor to ensure the health of her children. Poor access to health services due to lack of transport also contributes to this neglect.

RCH looks at the health needs of the woman in the reproductive phase. Her special needs during adolescence, post reproductive phase and menopause as well as health problems other than those of the reproductive system are **neglected** eg. **Cancer** (especially cervix and breast) and Unipolar Depression. Another issue is the need for **Hygiene during menstrual period.**

TB kills more women annually than all causes of maternal mortality combined. The impact of TB on women is more intense with the problems of malnutrition, ill health, HIV infection, repeated child birth, fear, stigma attached to the disease and the delay and access in seeking medical care. Although the overall prevalence of pulmonary tuberculosis is lower in women, the progression from infection to disease is higher. This could be because of the triple burden of house work, child care and employment leaving very little time for taking care of herself.

RTI / STI and AIDS are supposedly dealt with through the RCH program. But the biological vulnerability to these diseases, the lack of power to negotiate responsible behavior from their sexual partners and the non-availability of lady medical officers in adequate numbers, all contribute to increasing these eminently preventable diseases amongst women.

Violence is a very important factor leading to physical and mental health problems and a lowering of an already low self image.

There is an increasing **adolescent population** with specific needs which, have to be addressed.

Empowerment of the community, especially women, adolescents, the poor and the marginalized to make informed choices in issues relating to their health, amongst other important decision-making issues is the single most important factor that needs to be addressed if the health status of the community has to improve. Health Education will form part of the empowerment process and therefore will have to be addressed as a long-term, separate, planned activity.

Recommendations:

1. ***Sensitise all Health Care Personnel on issues relating to gender inequalities.***
2. ***Educate and promote personal hygiene especially during menstrual period by the distribution of subsidised menstrual pads/cloth through PDS.***
3. ***Services of Lady Medical Officer to be available at all PHCs.***
4. ***Improve diagnostic, medical and counselling services for STI & HIV/AIDS for the women as well as the sexual partner.***
5. ***Initiate efforts to identify gender related barriers to TB diagnosis and treatment and integrate into overall efforts to improve programme effectiveness. Identify sources of inequity.***

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

1. Activities to enhance empowerment of the women including poverty alleviation.
2. The Adolescent's needs for health information and services particularly with regard to nutrition, sexuality and reproduction.

7.2 PERSONS WITH DISABILITIES

Disabilities rob the basic rights of an individual to physical, mental, spiritual and social well -being. Disabilities include among others, locomotor, visual and learning disabilities; hearing and speech impairment; Mental Illness, Mental Retardation, multiple disability etc

It is estimated that 3 to 4% of the population in India have some form of moderate to severe disability. The 1991 survey of the Government of Karnataka showed a lower figure of 1% and the Action Aid surveys showed a rate of 2 to 3%. These figures may

have included only the severe cases, those that the families and community perceived as being disabled and needing interventions. 76% of the Disabled are in the rural areas and 24% in urban areas. Males form 58% of the disabled population. There are regional variations in the numbers as well as the types of disability.

Nearly 10% of disabilities in developing countries are caused by conditions which are preventable.

Globally programs for the Persons With Disability, which were earlier institution-based and expensive, have now become **Community Based Rehabilitation (CBR).** CBR seeks to promote the principles of universal coverage of services for Persons With Disability, at a cost that is affordable along with the promotion of integration, active involvement of Persons With Disability, their families and communities in the process. It seeks to enable disabled to become productive and contributing members of society, thereby reducing the burden of families, communities and nations with fragile economies.

Multi-sectoral collaboration between health, education, labor, vocational training, housing, welfare, sports and agriculture. NGOs, Disabled peoples Organizations (DPOs) and religious leaders within the community therefore is imperative. **The interventions to achieve this include** Prevention services; Early detection and stimulation; Discussing the child's capacities and problems and training the mother on how to stimulate the child; Inclusive education; Ways to integrate the persons with a disability into daily activities of home life; Self employment and income generation activities; Formation and support of self help groups of disabled persons, who help in identification of other disabled, training of parents of the disabled, formation of income generating co-operatives, etc.

In India, the Ministry of Welfare is the nodal agency for rehabilitation, which launched 11 District Rehabilitation Centers, one of which is in Talakaadu, Mysore District. In Karnataka, the Directorate of Welfare of the Disabled is part of the department of Women and Child Development.

The health care professionals and workers can play an important role in the prevention, early detection, intervention including corrective surgery and physiotherapy.

The other concerns include:

- The data in the areas of identification, classification, records of progress and evaluation are not comprehensive and complete. The recording systems vary widely, thereby making comparison difficult.
- Community Based Rehabilitation methodology is still not implemented adequatley; rehabilitation measures are still institution oriented.
- Most of the programs are carried out by NGOs who tend to be urban – based and cater to single disabilities.

- Networking unsatisfactory.
- Identification of people with mild disability and persons with learning disability, severe emotional problems and hyperactivity is not satisfactory.
- Availability of trained manpower for Community Based Rehabilitation is low.
- Existing training curricula and programs are biased towards institution based programs and are not standardised
- The latest developments in Community Based Rehabilitation are not available to people at the grass roots level.
- Technical aids in rehabilitation are often not appropriate to Indian conditions and needs.
- There is a need for co-ordination of activities of health, education, vocational training and welfare sectors.

Recommendations

1. ***Utilise Media to create awareness and training of parents and other care-givers on specific disabilities.***
2. ***Establish the role of the Health department in Disability Prevention, Early detection, Intervention, corrective surgery and physiotherapy.***

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

1. Shift from institutional approach to a Community Based Rehabilitation-home-(parent) based approach; and from single to a multi-disability approach.
2. Sensitize health-care workers on disability-prevention, identification, classification, records of progress and evaluation, referral and home-based stimulation training. Staff from Leprosy control programs may be trained first.
3. Minimize preventable disability. Identify and minimize sectoral loop-holes in the RCH & Immunization programs. The Health Department to take responsibility for Prevention, Physiotherapy and Corrective surgery.
4. Networking initiatives - Get all people, Govt. as well as NGOs, from all sectors to meet at a common platform and plan out strategies.
5. Implementation of specific training programs.

7.3 TRIBAL HEALTH

The health infrastructure for the Tribals in Karnataka include 31 PHCs and 10 Mobile Health Units. The predominant problem associated with this infrastructure is that many are not located in the identified Tribal areas. Vehicle problems and Vacancies make these health centers non-functional. Referral services are non-existent

Traditional Medicine being practiced by the Tribals is ignored. There is much difficulty in accessing the herbs in the forests.

The commonest diseases amongst the Tribals are Tuberculosis, Malaria, Anthrax and Leptospirosis. Substance abuse of Alchohol, Tobacco and Bhang is common. Sickle Cell Disease is prevalent.

The Nutrition status is poor. The Anganawadi Centres are not properly functioning. The Rice supplied through the PDS is not the staple diet of the Tribals. The supply from the PDS is poorly monitored.

The Drinking Water and Sanitation facilities are not satisfactory.

Child Labour and Bonded Labour are prevalent. The involvement and participation of the Community in Health and development programmes is poor and there virtually exists no Health education activities. The Voluntary Organsiations have played an important role in the health of the Tribals.

The Tribal ANM's programme under India Population Project 9 has had a positive effect.

Recommendations:

1. ***Strengthen the existing Mobile Health Units and the PHCs in the Tribal areas and make them all functional.***
2. ***Initiate a systematic documentation of Traditional Medicine with the help of Voluntary Organisations.***
3. ***Strengthening of the Tribal ANM project. The current batch of 27 needs to be posted on priority and a fresh batch of training to be initiated.***

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

1. All the Integrated Tribal Development Project (ITDP) Areas, to be covered under the Tribal ANM Project

2. The re-organisation and relocation of the Subcentres and PHCs in the Non-Tribal areas under Tribal Sub plan to be taken up.
3. The referral system to be strengthened.
4. RCH to be a major agenda in these Tribal areas.
5. Promote Traditional Medicine and integrate it into the current Health Care System.
6. Improve the quality of Health and Growth monitoring under the Tribal Sub Plan.
7. Screening and management of Sickle Cell Anaemia and G6PD Deficiency by Voluntary Organisations. Disease Surveillance systems to be set up for Tuberculosis, Malaria, Leptospirosis and Anthrax.
8. Include Ragi, Jowar and Pulses in the Public Distribution System.
9. Setting up of a Community Fund for Emergency and Referral services.
10. Incentives for Health Care Personnel who opt to work in the Tribal Areas.

8. HEALTH EDUCATION

8.1 HEALTH EDUCATION

Health Education can yield large dividends in improving the health of the people. It helps the people to attain and maintain health, understand the problems causing death, disease and disability and take appropriate action to promote health and prevent disease. But it is a neglected area.

Health Education is concerned with establishing responsible behaviour and in bringing about changes in the behaviour. It concentrates on developing health practices which can bring about the best possible state of well-being. Health education is a process that helps people to find out their health needs and activate them for suitable health related behaviour.

Health education must take into consideration the customs, beliefs and practices of the individual, the family and the community. Programmes need to be developed, which are suitable to the people of the area.

Karnataka has a rich heritage of folk arts (Yakshagana, Kathakalakshepa, drama, song and dance, puppet shows, street plays, etc.) which can be effectively used in health education. They have evolved within the culture of the society.

Other media can also be used effectively – the print and newspaper, electronic – AIR, Doordarshan, movies, posters and others. Face to Face communication and group discussions are effective. We need well-trained and motivated personnel with good leadership. They should make optimum use of the services of experts from different disciplines-sociology, community health, education and communication. Besides the State health directorate and the central health education bureau, there are voluntary organizations in Karnataka which can render significant service in carrying out health education programmes.

Recommendations:

1. ***Reorganise and integrate the different IEC programmes in the Directorate of Health and Family Welfare Services with professional inputs.***

8.2 SCHOOL HEALTH

Many personal habits and lifestyles that have important consequences for health are formed early in life. Health education in schools can help young people to make informed choices.

A sound school health education programme, during the formative period of the child, focuses on the circumstances that affect the health and well being of the child and through the child in other children, their families and the community, child to child, child to family and child to community.

School Health is important for education. School attendance is affected by health and disease among children and their families. Healthy children learn well; learning is affected if children are ill or malnourished.

School health checkups influence immediate problems, which affect learning: impaired vision, hearing and nutrition; anaemia due to intestinal parasites or iron deficiency. Schooling helps children adopt healthy lifestyles, which will then be continued. Mothers with some schooling take better care of their babies; they are more likely to seek medical care when needed and have their children immunized.

A health promoting school provides a healthy environment, health and nutrition education, school health services and physical education and recreation. It helps to prevent causes for death, disease and disability, such as use of tobacco, sedentary life style and injuries and accidents.

The curriculum must include all aspects of health, including knowledge of the structure and function of the human body, nutrition, human sexuality, sexual rights and responsibilities, reproductive rights and responsibilities, population issues, sexually transmitted diseases, HIV /AIDS, substance abuse including tobacco and alcohol, values and life skills, issues in marginalisation, disability and self-esteem.

Recommendations:

1. ***Initiate greater coverage of all students in all the schools in the State with health (including Dental) checkups and health education. Train the students in first aid.***
2. ***Use the media, including AIR and DD to promote health (similar to UGC Programmes).***

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

1. Promoting healthy life styles
2. Study the impact of different media of communication in different regions of the State, in disseminating health messages, so as to utilize the most effective ones.
3. Help the personnel and troupes involved in health education through folk media to improve the quality of their communication, especially to the rural.
4. Develop health education materials at the regional level suitable to the culture of the region.
5. Use AIR and DD to impart lessons in health
6. Equip the teachers in skills in effective communication of health principles and practices, utilising the syllabus in 1 to 10 standards. Revision of School curriculum from Health point of view and to make health education of the students effective.

9. HEALTH HUMAN RESOURCES DEVELOPMENT

Health services require large numbers of qualified and skilled professionals and staff. The present situation is one of over supply of medical graduates in the various systems. Karnataka has exceeded the norms for qualified professionals. Too quick expansion in the number of colleges tells on the quality of education.

There has been a mushrooming of new Colleges. There are at present 23 Medical, 36 Dental, 46 Pharmacy, 38 Physiotherapy, 43 Ayurvedic, 11 Homeopathic, 2 Unani and 3 Naturopathy and Yoga Colleges. Many of them do not have the necessary infrastructure and teaching staff as per the norms set by the different councils.

The situation is not better with respect to the Nursing education. There are about 150 schools of Nursing and 40 Colleges of Nursing. Many of them do not have adequate qualified staff or training facilities

Expansion may be necessary in some areas of paramedical education. There is need for more ANMs. The Departments of Health and Family Welfare Services (DHFWS) and Medical Education (DME) must make a comprehensive study of the requirements. Many of the Paramedical Job Oriented Courses are not of satisfactory quality.

Round the clock diagnostic (X-ray, Laboratory, etc.,) and blood bank services are not available in many of the hospitals including the Tertiary.

One felt need was the orientation and training of all health staff in Health Care schemes, Public Health, Ethics and Management.

Many persons who met the Task Force stated that there is widespread corruption in the conduct of University Examinations (undergraduate and postgraduate medical) and that the examiners demand and take money for giving pass.

Recommendations:

1. ***The issuing of essentiality certificate by the Government and affiliation by the University for new Medical, Dental, Nursing, Pharmacy and Physiotherapy Colleges should be stopped for the next three years, the exception being Nursing Colleges in under-served areas of Karnataka. Where essentiality certificate or temporary affiliation has been given but the College has not***

started functioning, the certificate and affiliation should be withdrawn immediately.

2. *Extend the moratorium on new Ayurvedic, Homoeopathy and Unani Colleges by another 2 years.*
3. *Take up urgently the repairs of the buildings of the Colleges, hospitals and hostels, equipments and vehicles of the Government teaching institutions and hospitals. All equipments must be maintained in good working condition.*
4. *Redeploy teaching and non-teaching staff according to the needs.*
5. *Streamline the working of emergency services like Casualty, Burns and Accidents and provide round the clock diagnostic (X-ray, laboratory, etc.) and blood bank services in all Teaching Hospitals. Essential drugs must be available at all times.*
6. *The State Institute of Health and Family Welfare to be upgraded and be made autonomous. The Institute and RGUHS should take up the training at all levels in management, public health and ethics along with Voluntary Organisations and Experts.*
7. *Increase the intake for the training of Auxiliary Nurse Midwives (ANMs). Encourage NGOs with the capacity for training to take up the training of ANMs*
8. *Every Medical and Dental College to adopt a block for service to the people of the area and training of students*
9. *Corruption at the University Examinations to be eliminated.*
10. *The teaching programmes in the Government Medical Colleges to be strengthened by invited teaching faculty and given suitable remuneration; they will not have clinical responsibility at the hospital.*

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

1. Every Medical College to be responsible for the health Care of one district in collaboration with the department of Health and Family Welfare services.
2. Monitoring and evaluation (performance appraisal) of the teaching and other staff once in 6 months.
3. Heads of Departments, Resident Medical Officers, Medical Superintendents, Principals and Directors should be given sufficient authority and be made directly accountable for the quality of the teaching and service. Officers must be made to follow the Duty Manuals. Plan training and retraining of the officers in management.
4. Every professional College to have an education unit to improve the teaching capability.

5. RGUHS to organize teacher training programmes
6. Reorganize the Directorates of Health and Family Welfare and Medical Education to integrate Health Care Services and Education.
7. Alternate strategies of Health Personnel development to serve in Rural areas.
8. Review of the Paramedical Job Oriented Courses.

10. HEALTH SYSTEMS MANAGEMENT

10.1 ADMINISTRATION

The cadre structure and the corresponding lines of management of health services have historically evolved on the basis of designated plan schemes and financing sources such as Centrally Sponsored Schemes, Central Programmes for specific purposes, Externally Aided Projects and the like. This has resulted in a diffusion of hierarchies in terms of focal control points and nodal points of responsibilities. It has also incidentally resulted in independent reporting systems with consequent dilution of the ability to monitor progress and performance in the activities of the Directorate. The internal mechanisms to build up the morale of the hierarchies and also enforce control and discipline have weakened considerably.

The efficiency of the health services has been eroded considerably. The management of the cadre in terms of filling up vacancies, postings and transfers, matching qualifications to job requirements and training has been weak. These, and related issues, need urgent attention. Some issues are capable of being tackled in the short term, while others would require further examination.

There is lack of co-ordination in the functioning of the Health and Family Welfare Department and of the associated departments. The systems of monitoring of both performance and expenditure, based on an efficient reporting system are very weak. This has to be an integral part of the activities of the department. But, temporarily, in order to remedy this present situation, a post of the Commissionser, Health and Family Welfare, has been created. The role, responsibilities and authority of the Commissioner have to be defined.

There are at present about 100 doctors with Postgraduate qualification in various disciplines serving at different PHCs, whose services can be better utilised to fill the vaccancies at Taluka level and above Health Care Institutions.

There are about 950 cases of Doctors on cases of absenteeism, misappropriation, traps and general complaints. Some of them are long standing.

The need for capable, professional management of the services in the department has been acutely felt. The department should identify and induct young professional managerial talent at the district and State level structures to give impetus to the programmes and services.

Recommendations

1. *All administrative posts in the Directorate to be filled up.*
2. *All the posts of Joint Directors and above to be selection posts.*
3. *The services of doctors with Postgraduate qualifications in various disciplines serving at different PHCs to be utilised to fill the vacancies at Taluka level and above Health Care Institutions*
4. *A Vigilance Cell in the Directorate headed by the Commissioner for disciplinary action against corruption, absenteeism and for speedy disposal of enquiries.*
5. *The process of regularisation of the contract Doctors to be commenced.*
6. *A transfer Policy to be evolved on the basis of well defined criteria, and implemented. The criteria could include a) a three to five year limitation in a particular post or place, b) a compulsory posting in the rural post (ensuring that positions in the less favoured areas such as Northern Karnataka are particularly covered) c) postings to the urban areas being available as seniority and personal responsibilities increase d) transfers of primary health centre (including subcentre) staff should be preferably be within the district. In making transfers the mismatch between the qualifications of the officer and those required for the post should be corrected. The principles adopted by the Education department would provide useful guidelines*
7. *About 100 Doctors from the Department to be selected through a transparent "search-cum-selection" mechanism assisted by the Task Force, given intensive training in management and placed at the Directorate and DHOs Offices as Programme Managers.*
8. *The selection of Inservice Doctors for Post Graduate courses should be based on the needs of the Department for specific specialisations and not on the preferences of the officers. A review of the needs to be made for this purpose.*
9. *The practice of postings of Officers on OOD should be kept to the bare essential. This would ensure that postings based on individual preferences or to avoid transfers are minimised.*
10. *The role and responsibilities of the Commissioner, Health and Family Welfare may be defined as follows – "The Commissioner, Health and Family Welfare shall be responsible for monitoring, supervising and implementing all National and State Health and Family Welfare programmes in the State. The Commissioner shall also be responsible for ensuring coordination among the various Directorates and Divisions within the Health system and also with related Departments". The specific responsibilities are indicated in Annexure 7. Sufficient administrative and financial authority to be delegated to the Commissioner to perform the responsibilities effectively.*
11. *The system of performance appraisal (confidential reports) to be implemented.*

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

A review of the structure of the health services would be done and all relevant issues would be included in this review. Some of the issues that would need attention would be

1. Review of the structure of the Directorate to consider possible and desirable changes; delegation of authority both financial and administrative, control mechanisms; training; maintenance of assets, and other relevant issues.
2. Consideration of the reinstitution of a strong Public Health element in health services. This would include inculcation of an appreciation of the needs of the rural areas, compulsory rural postings and making rural and public health experience a condition for career prospects.
3. Consideration of a mechanism for attending to public complaints and complaints relating to corruption by the establishment of a District Committee with the Deputy Commissioner as Chairman, the Chief Executive Officer, Superintendent of Police and DHO as members along with two or three prominent local NGO representatives.
4. Issues relating to private practice by Government doctors.
5. Issues relating to corruption and associated matters.
6. Consideration of the externally funded projects with reference to sustainability and institutionalisation of both work culture and performance levels, relationship with the DHS and connected issues.
7. Preparation of a perspective plan for the Directorate that takes into account programme needs, staff issues, financing.
8. Any structural changes that may seem necessary, including the creation of a distinct Public Health Cadre in the Directorate. This would include recognition and consideration of related issues of cadre formation, cadre options for staff and the like.
9. Mechanisms for enhancing the participation of the private sector for augmentation of health / medical services – Induction of private specialists wherever necessary and induction of lady doctors in rural areas.
10. Developing a possible mechanism for providing support to the DHS through induction of external expertise for monitoring and providing planning support.
11. Reorganising PHCs, taking into consideration staffing structures, equipment, future locations and other relevant factors.
12. Establishment of Advisory Board of Health with defined functions, for providing the necessary support to the system.
13. Citizens Charter for all Health Care Institutions.
14. Review of the existing Cadre and Recruitment Rules.

10.2 PLANNING

Health services must meet current needs. It would, therefore, be necessary to review the system periodically in terms of both content and adequacy. The character and content would be influenced by the population projections and also by the need to cater to under-serviced areas in the State. Any modifications or expansion of services have implications in terms of staff, training, and financial outlay. It would, therefore, be necessary to have an in-built ability for carrying out such reviews and in the preparation of perspective plans.

A Planning Unit in the Directorate would be needed with this capacity. The unit should be responsible for preparation of the Five Year Plans and Annual Plans of the Directorate and for the preparation of the long-term perspective plan. It would also have to develop the capability to monitor progress in adoption and implementation of such plans. Expertise in both physical and financial planning would have to be available in-house. Its importance would have to be recognised by assigning to it an appropriate place in the administration and management tree. Its staffing and other features would be studied.

The lack of appropriate health human resources has affected the services provided by the Health Department. The Health Humanpower requirement should be assessed and developed to meet the present and future needs also.

The establishment of a Geographical Information System in the Directorate is recommended. The system would be most useful for assessing the adequacy of health services and planning future needs. It would be a most useful management and planning tool. Incidentally, the computer system that would have to be established for this purpose could, at appropriate levels, also be used for the Health Information Management System.

Recommendations:

1. ***A suitable structure for the Planning Unit in the Directorate, and descriptions of its functions to be prepared to address the issues of long time, 5 year and annual plans, the Physical, Financial and Human resources plan.***

10.3 FINANCING

In assessing the financing of the health sector, the issues would be (a) adequacy of funding in relation to the current and possible future scale and responsibilities of the Department, (b) the adequacy of financial delegations and a review of current

delegations, (c) operational issues relating to reduction of accounting workload at field levels and simplification of procedures, and (d) the relationship between the aided projects and the DHS which has both administrative and financial implications.

In the year 1999 – 2000, the Plan provision under Medical and Public Health was Rs. 3706.45 lakhs of which the expenditure is of the order of 1171.14 lakhs. Even assuming further expenditure would be booked in the revised estimates, there is a massive under-utilisation of funds. Under Non-Plan, the provision was Rs. 12098.58 lakhs while the expenditure is of the order of Rs. 6808.96 lakhs. The latter shortfall is mainly because staff positions have not been filled.

The under-utilisation of funds has serious implications. It would imply that performance and improvement of health services are inadequate. It is necessary to improve the mechanisms for periodic review of both physical and financial progress. Such a review is again dependant on the establishment of an efficient, timely and adequate reporting system. The Commissioner, Health and Family Welfare, could carry out such a review.

Elsewhere in this report it has been recommended that all posts should be filled expeditiously, particularly those at the primary levels such as ANMs, other categories of health workers, laboratory technicians, etc. If these posts are filled, corresponding needs for equipment, including kits for Dais, would have to be met. Sufficient provision would have to be made for the latter.

Recommendations:

1. ***Additional Resources to be provided during 2000 – 2001 to carry out the reforms suggested.***
2. ***Monitoring of expenditure, specially plan programmes to ensure adequate utilisation and results must be done.***

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

The financial needs of the Directorate would be reviewed. The important aspects that would be considered would include:

1. The long term needs of the Department taking into consideration the perspective plan that would be formulated and the structural changes that may be considered necessary.

2. The internal financial delegations to permit more effective decision making at the various functional levels.
3. The accounting burden at the field level would appear excessive. These procedures and the financial reporting systems would also need review.

A comprehensive review of the financial management system is envisaged and a plan of action would be prepared.

10.4 HEALTH INFORMATION MANAGEMENT SYSTEM

The need for periodic monitoring of performance of the health system scarcely needs emphasis. At present the monitoring system is not uniform and does not provide the management information that it should. Different monitoring systems and formats, dependent on the particular programme they relate to, now exist. There is no coordination among these vertical reporting systems, resulting in both lack of utility and waste of internal resources. An efficient monitoring system would have to be developed and instituted.

There are distinct features of the health system that would need to be monitored. These would include monitoring of (a) the physical performance of the system in terms of identified parameters, (b) financial management, and (c) personnel matters. The monitoring system would also have to provide for management at the micro level and assist in the sensitive and efficient appraisal of information. It should permit administrative and technical inputs that would reflect performance so that continuous internal evaluation is possible. The information system must provide for feedback to the operational levels.

A complete review of the current systems of reporting is envisaged. Such a review would take into account the type and content of the information that would be useful, and its periodicity. It would also specify the reporting formats and the flow of information. The objective would be to establish a uniform reporting system that would permit efficient appraisal of performance on the basis of set parameters, and which would help in better administration of health services.

The integration of the data base with the GIS referred to early would also be ensured.

The information system for management of health services, particularly if it has to have the added advantage of a GIS overlay, would be enormously enhanced if the system was computerised. In any case, the GIS is computer based. The advantages of a computerised system at all levels are well known in terms of maintenance, retrieval

and analysis of the information. It would be desirable to computerize the health management system from the PHC upwards at some point of time. However, such large-scale computerisation would have to be well planned and carried out in stages. As a beginning, it would be desirable to computerise the offices of the DHO as soon as possible.

The utility of the information system is dependent on the efficiency of the reporting mechanisms. Deficiencies in the latter, including late or incomplete receipt of basic records would seriously reduce its utility. At present, it is noticed that reporting is weak because, among other reasons, of the inadequate supply of forms of reporting and registers. It many cases, the staff use odd sheets of paper for reporting and this increases the difficulties of record maintenance. It should be possible to arrange for timely printing and supply of all forms and registers in adequate measure, particularly since the requirements are known and tend to be constant over the years. It is recommended that this matter be monitored by the Directorate of Health Services and that arrangements are made for such supply.

Recommendation

1. ***An integrated, comprehensive Geographical Information System based HIMS to be initiated and implemented.***
2. ***All the District Health Officer should be computerised for efficient management and control of Health System in the district.***
3. ***The formats / registers needed at various levels to be updated, printed and supplied in adequate quantities and on-time.***
4. ***Annual reports and monthly updated programme performance to be placed on website of the Directorate for information.***

10.5 MEDICINES PROCUREMENT AND SUPPLY

The methodology of arriving at Annual Medicinal drug requirements for the health care Institutions in the State is at best experienced estimates or at worst adhoc. The Government of Karnataka purchases the Drugs required as per Rate Contract document. The Government Medical Stores, GMS, Bangalore in the Directorate of Health Services is the nodal agency for the procurement of these medicinal drugs. The Rate Contract was not processed in two previous years.

It was noticed that Not all the essential drugs were covered under the Rate Contract system. The MO (of PHC/ CHC/ Taluka Hospital/ District Hospital) is responsible for indent. The MO or his representative has to travel all the way to the GMS in

Bangalore to procure the indent. The efforts to establish District stores has not been completely functional.

It was noticed that the available medicines included near expiry date medicines. It was also reported that Medicines which are not required (either because of available stock on hand or simply unnecessary) had to be taken. Eg: 300 vials of Fortified Pencillin with expiry date of February 2000 was supplied to a Health Care Institution at the end of January 2000; when the monthly requirement did not exceed 20 to 25 vials or maximum 30 vials.

The Rate Contract system provides for the lowest bidder to be contracted first. When the lowest bidder fails it is expected the next lowest bidder would be approached. This results in delay in procurement and sometimes loss of money to the exchequer. A system needs to be set up when the procedural delays would not be at the cost of the patient.

The Primary Health Centres indent for medicines worth Rs. 50,000 per year. (The norms for other institutions vary) This stock of Medicines was said to be sufficient for about only three months. However, it was discovered that there are 13 different sources from Central and State sources, which the health Care Personnel of the PHC can obtain the drugs. Not all are perennial and reliable sources. This definitely warrants a review of the situation in toto.

As noted above, the Central Government also supplies the requirement of some of these medicines, especially under the Maternal and Child Health programmes. It was reported that there was no Central supply of IFA tablets for two years. This led to a situation when IFA tablets were not available for the patients for two whole years. This is highly deplorable. Remedial and back up systems should be delineated in such unforeseen (? !!) circumstances.

A preliminary analysis of the previous three year purchase of medicines under the 60% ZP quota was undertaken. It was noted that not all purchases were generic. In instances it was found difficult to justify the purchase of the drugs. The Task Force eagerly awaits the report of the special committee constituted to review the situation.

Recommendations

1. ***The Rate Contract System***

   a) ***to be based on the exhaustive list incorporating the features of the WHO and the National Essential drug list;***

b) *if there is no bidder for any essential drug, suitable alternative arrangement to be delineated for purchases to be made.*

2. *The RC should specify the total requirement of the drugs for the entire State including that of ZPs and include all sources and not just 40% of the GMS quota.*

3. *The ZP or any other drugs procurement agency for Government Health Care Institutions in Karnataka should restrict to the drugs listed in the RC. Exceptions to be made with not greater than 10% of the allocated norm.*

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

1. The Health Care Institutions should provide the list and quantity of Drugs for the annual requirement by the end of the year (31st December) based on the Morbidity load and also previous experience.. The collation successively at the district and State levels to be the total requirement of the Drugs for the State.
2. The RC should specify the consignee of the drugs and all efforts to be made to supply the quantum of drugs indented at the door step of the Health Care Institution. Though costly this system would solve a lot of hassles for the health care institution.
3. It is necessary that the exercise of processing of the fresh RC should begin by the month of December and completed by the time the current RC expires.
4. If the Central government supplies are either delayed or not forthcoming immediate alternate purchases to be made. Reimbursement including the higher costs incurred if any, to be claimed as matter of right and responsibility.

10.6 LAW AND ETHICS

There are many laws in the State, which regulate the health professionals and health care institutions. These are scattered widely in many pieces of legislation. Further, most of the laws are not effectively implemented.

Problems in implementation

An example of non-implementation of the laws because of loopholes is **female foeticide**, which is increasing in the State. To prevent female foeticide, the Pre-natal Diagnostic Techniques (Regulation and Prevention of misuse) Act, 1994 was enacted. But it has failed to achieve the objective. Medical termination of pregnancy is permissible (Medical Termination of Pregnancy Act 1971 and Rules 1975). What is illegal is pre-natal sex determination and **sex selective abortion**. The person who conducts the sex determination (usually ultrasonologist) communicates only orally;

there is no written evidence. One doctor identifies the sex of the foetus; another doctor terminates the pregnancy.

Another example is the **Human Organs Transplant Act, 1994**. The purpose was to stop or at least reduce the unethical practice of sale of organs (usually kidneys) by unrelated donors and to promote cadaver transplants. But the sale of kidneys goes on within a system of touts and sharing of the booty by all involved.

New Bill, 1999

Karnataka had "the Karnataka Private Nursing Homes (Regulation) Ordinance, 1976 and the rules there under. But this was never implemented. A new Bill, 1999 has been introduced in the Legislative council. Considerable changes are needed to make it effective and acceptable. The aim should be **quality assurance**. This needs appropriately defined standards relevant to the size, type and location of the health care institution (hospitals, nursing and maternity homes, blood banks, diagnostic centres and others), based on social, economic and cultural situation.

Quackery

Unqualified and untrained persons often practice medicine. Such unlawful practice may take different forms

- Totally unqualified person practising any system of medicine or treating patients
- A person qualified in one system of medicine, practising another system of medicine, in which he or she is not qualified.

Wrong medication can lead to adverse reactions. Inappropriate use of drugs can cause drug resistance. Delay in proper diagnosis and treatment can be hazardous, preventing cure and causing complications.

Accreditation

Voluntary process of accreditation of health care institutions can assure quality of service. Standards are worked out by a recognised body, which carries on an inspection. Based on the results of the inspection, the health care institution may be given accreditation. This process is invogue in many countries. It is a process of **self-regulation**.

Ethics

All professions have codes of conduct. Thus, there are codes of conduct in Medicine, Nursing, Dentistry, etc. There are Councils for the health professions with powers of disciplinary action. But these powers are seldom exercised. There are many instances of malpractice, negligence and incompetence. Many of the Councils do not even know the number of the professionals practising in the State, because of lack of renewal of registration.

Recommendations

1. ***The legislation introduced in the Legislative Council to regulate the functioning of Health Care Institutions should be sent to a Select Committee to elicit views from all concerned (stake-holders, professionals and public).***
2. ***Take steps to renew the registration of health professionals once in 5 years with the respective State Councils. Initiate steps to register all Health Care Institutions***

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

1. Identify the loopholes in the existing laws affecting health professionals and health care institutions. Initiate measures to plug the loop holes. Implement the laws effectively
2. Enact a new Public Health Act, based on the Model Public Health Act (1987), with suitable modifications.
3. Examine in depth the problem of quackery and take steps to stop it.
4. Monitoring by an independent agency of Organ Transplants in cases of unrelated living donors and promotion of cadaver transplants
5. Make the teaching / learning of ethics as part of health professions education.
6. Have training programmes in medical ethics for all health professionals.
7. The respective State Councils should ensure that the members of the health professions practise ethically, following the codes of conduct

11. INDIAN SYSTEMS OF MEDICINE AND HOMEOPATHY

11.1 AYURVEDA, UNANI AND HOMEOPATHY

The Indian Systems of Medicine have been functioning for thousands of years. The department of Indian System of Medicine and Homeopathy (ISM&H) was bifurcated from the Department of Health in 1972. These systems continue to be popular with the public. The department renders medical relief in Ayurveda, Unani, Siddha, Naturopathy, Yoga and Homoeopathy and facilitates medical education, drug manufacturing, publication and practice of medicine in these subjects.

The budget allocation for the Department of ISM&H is less than 1% of the total health budget. This is very inadequate.

There has been a mushrooming of new Colleges in these systems. At present there are 43 in Ayurveda, 15 in Homoeopathy, 3 in Unani and 2 in Naturopathy and Yoga in the State. Many of them do not have the basic infrastructure and faculty.

There is a disparity in the scales of pay between those qualified in ISM&H and those qualified in Modern Medicine, so also there is disparity in the stipends for house surgeons and postgraduate students.

Many Ayurvedic medicines have short shelf-life (6 months); the supply to government dispensaries is once a year; the potency of medicines will be lost. The amount for the dispensaries is Rs. 18,000/- per annum. This is too meagre to meet the requirements.

The existing buildings of hospitals and dispensaries require repairs and renovation. There are many vacancies of the post of physicians. 8 districts do not have ISMH hospitals. Cities and municipal towns do not have enough dispensaries in ISMH. There is no well-equipped drug-testing laboratory to identify spurious and adulterated drugs.

Recommendations:

1. ***Plan and initiate action to have ISM&H wings in the existing District /Taluka hospitals.***
2. ***The drug licensing authority should ensure the printing of the date of manufacture and date of expiry of drugs on the containers.***

3. ***The supply of medicines to hospitals and dispensaries must be quarterly to avoid loss of potency.***
4. ***The budget allocation per dispensary should be increased to Rs. 36,000/- per annum.***
5. ***The stipend for the Interns and Postgraduates to be enhanced.***
6. ***Steps to be taken to conduct Entrance Tests for selection to Postgraduate courses***

ISSUES AND CONCERNS FOR MEDIUM AND LONG-TERM CONSIDERATION

1. Reducing the disparity in the pay scales of Doctors in ISM&H and Modern medicine

11.2 FOLK MEDICINE AND TRADITIONAL MEDICINE

Karnataka has a rich tradition of folk medicine / traditional medicine. We have both codified and oral tradition. There are a large number of folk medicine people (Carriers of oral tradition) who treat chronic and common illnesses. Traditional birth attendants are an important health resource in our country.

Folk medicine is community supported. It is decentralised, locally available and culturally acceptable.

Hundreds of different species of plants are used for medicinal purposes in Karnataka. The prime need is to conserve the plants growing in the natural state. Cultivation of the identified plants in situations similar to the natural habitat needs to be urgently addressed.

ISSUES AND CONCERNS FOR MEDIUM AND LONG-TERM CONSIDERATION

1. Steps to be initiated to document and conserve the plants used by the folk medicine people.
2. Cultivate the medicinal plants on a large scale so that they do not become extinct with their increased use.
3. The rights and access to procure medicinal plants to be safeguarded.

12. PANCHAYAT RAJ AND EMPOWERMENT OF PEOPLE

12.1 PANCHAYAT RAJ INSTITUTIONS AND HEALTH

Health care must be what the people perceive as their need at a point of time and must be available where the people are. It would have to be community based and the mechanisms for intervention by the community must be built in. The latter is appropriately through the panchayat institutions.

The advantages of involvement of the panchayat institutions in implementation and management of health services are that focus on vulnerable and special groups would be enhanced, preventive measures would get emphasised and services would, instead of being on a uniform pattern be modified to meet specific local needs. Inter-sectoral coordination with programmes closely related to health such as sanitation and water supply would also be facilitated. It is necessary to involve the panchayat institutions in the administration of basic health services at all the three levels – village, taluka and district.

The temporary difficulties in doing so are recognised but these are not insurmountable. These include problems of perception of mutual roles of the panchayat body and the technical officials, likely emphasis on creation of physical assets, etc. However, with training of the members in their duties and responsibilities not merely under the Act but to the community, these issues should be capable of being sorted out.

The Karnataka Panchayat Raj Act, 1993 specifies the responsibilities of these bodies regarding health services. It also prescribes the mechanisms, through Committees, for performance of these duties. However, for increasing involvement of these institutions in the management of health services at the community level, it would seem essential to create further awareness in the community of their entitlements and how they can access these entitlements through their representative organisations.

At present there is no full-time trained health functionary at the Village level. The Gram Panchayat should appoint a woman of the village for this purpose as a health functionary. Such a functionary should be appointed for each of the villages falling within the jurisdiction of the Gram Panchayat. This Village health functionary would undertake the necessary field activities relating to Health, Nutrition, Water supply and Sanitation and Population within the each village and bring about co-ordination between Gram Panchayat and Health Care Services.

Recommendations:

1. ***Training must be imparted to the new Panchayat members regarding their responsibilities and duties, with respect to Health, Nutrition, Drinking Water and Sanitation, Population and co-ordination with the health staff and need for monitoring health programmes.***
2. ***Women members of Panchayats should be separately oriented to the RCH, ICDS and similar programmes. They should be motivated to take on the role of community leaders in health and health-related issues.***
3. ***The Gram Panchayat should appoint a woman health functionary at Villages where there is no ANM or Anganwadi worker for assistance to the ANM/Dai to look after the new born at the time of delivery and in the management of Health, Nutrition, Drinking Water and Sanitation, Population. This could be initiated atleast in a few districts where Human Development Index is low.***

12.2 PEOPLES EMPOWERMENT FOR HEALTH

"Peoples Health in Peoples Hands" could be achieved through Health awareness and education, enabling the Community to understand their health situation in their Villages, make them prioritise their health needs and prepare Village Health Action Plans. This could be done through Health campaigns, Participatory techniques like PRA, PLA and Micro-planning exercises.

Village communities who are enthusiastic could form Village Health Committees. The Village Health Committees should consist of Gram Panchayat member, Health Worker, Anganwadi Worker, School teacher, leaders of the community, Representatives of self help groups, Village education committees, Mahila Swasthya sanghas and Youth Clubs. Atleast 50% of the members should be from the marginalised people (SC & STs) and 50% of the members should be Women members. Similarly "Sub-centre Health Committees" and "PHC Health Committees" also could be formed.

Village health Committees must meet every month. It should review the activities undertaken during the month and also review the subsequent Monthly plan. The Village Health Committees will help the Health Worker to undertake the planned activities and make the services accessible and available to the people. They also make the Health worker accountable to people.

Recommendation:

1. ***A pilot project in one district to have health committees at Village, Subcentre and PHC levels.***

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATIONS

1. Amendments to the Panchayat Act to provide for greater attention to health and related social sectors.
2. Social issues such as need to raise the age at marriage, personal hygiene should receive emphasis in training and later, in the Committees;
3. Institutions such as ISEC could be requested to prepare model plans of development, including health, which would facilitate planning by these bodies.
4. The Pilot Project learning to be extended to the entire State.

13. STRENGTHENING PARTNERSHIPS

We have a mix of health Care providers: Public, Voluntary and private. The Non-Governmental Organizations comprise of two large groups:

- Voluntary (not-for-profit) organisations;
- Private / Corporate (for-profit) sector.

They constitute a sizable number, whether it be in relation with the care provided, the number of persons attended to, the number of personnel or the number of institutions or beds or the expenditure by the people.

The government has the responsibility, as per the Constitution, to provide for the health care of the people. Voluntary Organisations have been playing a significant role in providing health care services. They are often supported by International Orgnaisations. Sometimes International Orgnaisations may be directly involved in health care. The health care needs of the people are met largely by private practitioners. Often they are the first level of contact. They are involved almost exclusively in curative acre. There are private Nursing Homes and corporate hospitals. They also provide mostly curative care.

The attitude so far has been generally one of confrontation, or at best, one of co-existence. Can we change it to one of collaboration and co-operation? Each one can learn form the others. The government is involved in Primary Health Care and Public Health. Can the Voluntary and private Sector be motivated to get involved to a greater extent in Primary Health Care and Public Health? The Voluntary sector is well motivated. Can their example be used to make the Public and Private Sectors better motivated?. The private sector is good in management. Can the Public and Voluntary Sectors learn better management (personnel, materials, money, time and information) form the Private sector? The government must take the initiative to bring about the changes.

Many corporate organisations are now willing to contribute a small percentage of their profit to meet the social and community needs. These sources need to be tapped and channelised to meet the health needs of the people. One method is to build trusts for funds on a district basis to which these organisations and others can contribute. The trustees of these funds should be public persons of known integrity from the district and willing and able to devote time to ensure proper utilisation of the funds for the Primary Health Care in the district. The members of the Parliament and legislators, hailing form the district, can play a key role in mobilising funds, without strings attached.

13.1 VOLUNTARY ORGANISATIONS

There are a large number of Voluntary Agencies working in the field of Health and Family Welfare in Karnataka. There are two types

- National / State Voluntary Agencies
- International Voluntary Agencies;

The Voluntary Organizations work at different levels :

- Grass-roots level in health, education, environment, etc.
- Training, networking, supporting other organizations
- Focussing on advocacy, lobbying, policy issues, etc.

The Voluntary Organizations are scattered throughout the State but are more concentrated in the Southern districts and based more in the cities.

Many Voluntary Organizations work with the Government. There has to be clear understanding of partnership between the Government and the Voluntary Organizations.

Strengths of Voluntary Organizations

Voluntary organizations have greater freedom to implement the programmes than the Governmental agencies
The workers in the Voluntary Organizations are generally more dedicated.
The programmes handled by Voluntary Organizations are mainly localised. Implementation of programmes is easier and quicker.
There is less hierarchy, making the functioning smoother

Weaknesses
There is often a lack of second line leadership, which can affect sustainability.
Voluntary agencies may suffer from lack of funds at times. Those Voluntary agencies, depending on external funding may have to stop the programme, if funding is stopped.

Recommendations

1. ***A Directory of Voluntary Organizations working in Health and Health-related work in Karnataka should be brought out immediately and updated periodically.***
2. ***Introduce a single window Voluntary Organizations Cell at the Health Directorate to co-ordinate the different programmes and simplifying***

procedures for grant-in-aid avoiding delays. Commissioner to be the nodal officer.

13.2 PRIVATE AND CORPORATE SECTOR

The private sector (general practitioners, nursing homes and corporate hospitals) play a large role in the health care (mostly curative) of the people of the State. Their role must be understood and encouraged to provide holistic services.

Recommendations

1) ***Use the services of private practitioners and specialists where there is lack of such personnel in the Government sector, paying for their services on mutually agreed terms. In case of deficiency of doctors in PHCs Private Practitioners may be appointed on "adhoc" basis***
2) ***Involve organizations of doctors in IEC activities and national programmes.***
3) ***Provide drugs and vaccines in the national programmes to the private practitioner for the benefit of the economically poor.***
4) ***Tertiary hospitals in Private sectors may provide training programmes for the government doctors***

ISSUES AND CONCERNS FOR MEDIUM AND LONG TERM CONSIDERATION

1) Work out the logistics of partnership concept between Government and Voluntary Organizations.
2) Involve Voluntary Organsiations in planning, implementation and monitoring of Health Programmes.
3) Enactment of Nursing Home Bill with necessary changes
4) Have the hospitals owned by the private / corporate sector to reserve 10% of the beds for people below the poverty line.
5) Family and group Insurance schemes for all including villages to be worked out and encouraged
6) Formation of Quality Assurance committee with the help of professional bodies for self-regulation.

14. SHORT TERM RECOMMENDATIONS AND PLAN OF ACTION

The Task Force on Health and Family Welfare has identified certain recommendations that demand immediate attention keeping with the thrust of the Task Force, Terms of Reference and deliberations, to strengthen health care in Karnataka with special focus on Primary Health Care and Public Health. These recommendations are implementable in the short term.

The overall thrust of the recommendations is to strengthen **Equity with Quality** in Health Care Services in the State i.e., to focus on those who need services most and to provide them with services which are of the best possible quality, within the limitations of resources and other constraints, under which the health sector functions today.

As the process of review proceeds, we hope to evolve a framework of Comprehensive State Health Policy that will make a functional Primary Health Care and a strong Public Health System, a reality of the State of Karnataka.

1. Primary Health Care

1.1. RURAL HEALTH

1.1.1. All vacancies of Doctors, Laboratory Technicians and ANMs at PHCs and Subcentres must be filled up immediately.
ACTION: ***Government, DHFWS***

1.1.2. All key staff, including Doctors, Staff Nurses / ANMs and other essential staff, attached to the Primary Health Centres must stay in the quarters. Where repairs are necessary they should be carried out immediately; where there are no quarters action may be taken to construct them; if quarters are not available, houses may be taken on rent;
ACTION: ***DHFWS***

1.1.3. The allotment for Essential Medicines (including Life Saving Medicines) must be increased by atleast Rs. 25,000/- per annum per PHC. All Essential drugs must be available at the PHC at all times.
ACTION: ***Government, DHFWS***

1.1.4. Every PHC must have a Telephone.
ACTION: ***DHFWS***

1.1.5. Atleast 1000 PHCs in the State must be made fully functional satisfying the above criteria, within the next 6 months
ACTION: ***DHFWS***

1.2. URBAN HEALTH

1.2.1. The Urban Family Welfare Centres and Health centres under India Population Project VIII should be involved in Comprehensive Primary Health Care.
ACTION: ***DHFWS, Bangalore Mahanagara Palike, Department of Urban Development***

1.3. REFERRAL SERVICES: Secondary and Tertiary Health Care

1.3.1. Complete the Secondary Care Institutions in progress under KHSDP (100 Secondary Care Hospitals) in the next Six months and make them fully functional with adequate Human power, equipments and accessories. The OPEC Hospital in Raichur must be made functional as early as possible. Work out effective linkages of Primary Health Care Institutions with the referral hospitals.
ACTION: ***Government, PA-KHSDP***

1.4. EMERGENCY HEALTH SERVICES

1.4.1. Improve the capability of the Health Care Personnel at PHC to attend to emergencies. The Emergency services should also cater to all emergencies, including Obstetric and Gynaecological cases, poisoning cases and Dog and Snake bites. Polyvalent anti-Snake Venom Serum must be made available at all PHCs at all times as a life saving measure.
ACTION: ***DHFWS***

1.4.2. Well-equipped Ambulance Vans with well-trained paramedics must be positioned on the National and State Highways to attend to accidents. Network the Trauma Centres with the Taluka / District Hospital; with adequate Communication facilities. SGARRC and NIMHANS to be the nodal Centres.
ACTION: ***DHFWS, PA-KHSDP***

1.5. LABORATORY SERVICES

1.5.1. All laboratories must be staffed with trained technical persons and equipped with the necessary instruments, accessories and reagents. Fresh appointees must be given orientation training before posting and existing staff should be given refresher training.
ACTION: ***DHFWS***

1.5.2. The PHC laboratories must provide prompt and efficient service for the diagnosis of TB, malaria, leprosy and RTI/UTI; other routine investigations must be available.
ACTION: ***DHFWS***

1.5.3. Rs. 30,000/- per PHC to be initially earmarked for the purchase of Microscopes (about Rs. 15,000/-), glass ware, equipment, other accessories and reagents.
ACTION: ***Government, DHFWS***

1.6. BLOOD BANKING AND TRANSFUSION SERVICES

1.6.1. The eight districts in the State which do not have a Blood bank to have atleast one blood bank each
ACTION: ***Government, DHFWS***

1.6.2. A study to be initiated and concrete proposal(s) to be developed to ensure and make available safe blood to the needy in the districts. The proposal to also review the existing guidelines and their feasibility. A representation to be made by the State Government to the Government of India in this regard.
ACTION: ***Government, DHFWS, Drugs Controller***

2. Public Health

2.1. STRENGTHENING THE PUBLIC HEALTH SYSTEM

Human Resources for Public Health

2.1.1. A short two week course on Public Health principles and practice for Taluka and District Health Officers at the State Institute for Health and Family Welfare. Short in-service orientation courses on public health principles and programmes for PHC Medical Officers.
ACTION: ***DHFWS, Director-SIHFW, RGUHS, All Medical Colleges, Experts***

Structural Issues in the Public Health System

2.1.2. A review of the Externally Aided Projects to be initiated to facilitate their absorption into the Health System. Sustainability and consolidating the gains/ achievements to be the primary objective.
ACTION: ***Government, DHFWS, VOs***

2.2. NUTRITION

2.2.1. Define and establish the items of coordination between the Health Sector and ICDS. These must include:

(a) A mechanism to detect, take corrective steps and monitor children with mild to moderate undernutrition.

(b) Coordination in detecting and treating infectious diseases in children, especially diarrhoea, skin and ear infections with appropriate care.
ACTION: ***DHFWS, Department of Women and Child Welfare***

2.2.2. Weaning foods for Infants and children above six months to be made available under the ICDS scheme.
ACTION: ***Government, Department of Women and Child Welfare, DHFWS***

2.2.3. Systematic promotion of kitchen gardens supported by seed/seedling supply. Drumstick, Chakramuni (*Chikermane*), Amaranthus, Papaya, local beans, are some examples.
ACTION: ***DHFWS, Forest and Horticulture department***

2.2.4. Upgrade the post of Deputy Director of Nutrition (Dept. of Health) to Joint Director and expand the role and job description of the JD to fulfill the responsibilities and implement and monitor Nutrition programmes.
ACTION: ***Government, DHFWS***

2.3. WATER SUPPLY AND SANITATION

2.3.1. Ensure regular water quality testing facilities in all the districts. The monitoring to be facilitated and coordinated by the District Surveillance Units. The PHC and Taluka Medical Officer should visit all sources of Drinking Water periodically.
ACTION: ***DHFWS, RDPR***

2.4. WASTE MANAGEMENT

2.4.1. Ensure proper segregation of Waste and total waste management at all health care institutions.
ACTION: ***Health Care Institutions, Government, DHFWS***

2.4.2. All health care institutions including Primary Health Centres and General Practitioners Clinic, should develop a policy and action plan for safe management of waste generated in their premises. The segregated waste streams should not get mixed up with general solid waste.
ACTION: ***Health Care Institutions, Government, DHFWS***

2.4.3. Initiate orientation and training of Health Care Personnel for proper waste management practices including practice of Universal Precautions.
ACTION: ***Health Care Institutions, DHFWS***

2.4.4. The government should support initiatives for common waste management treatment facilities.
ACTION: ***Government, Local Self Governments***

2.4.5. A Sanitary Landfill site must be identified for all Towns and Cities by local bodies, with assistance of the Health Department.
ACTION: ***DHFWS, Urban Development, Local self Government, VOs,***

2.5. COMMUNICABLE DISEASES

2.5.1. Sputum (TB) and blood smear (Malaria) results on every sample to be reported within 24 hours of specimen collection; 5% random sample check by supervisory staff. Induction training and refresher course of Laboratory technicians by rotation.
ACTION: ***DHFWS***

2.5.2. One Day Workshop each for Tuberculosis and Malaria to help the rational implementation and vitalise the TB control and Anti-malaria programmes in the state. The participants to include State and District Officers and all Professors of Medicine of all Medical Colleges in the State and representatives of all relevant Professional Associations.
ACTION: ***DHFWS, NTI, MRC, ROHFW, DME, NGOs,***

2.5.3. Choose one model of Communicable Disease surveillance (in contra-distinction to HMIS) after considering the model developed by KHSDP.
ACTION: ***DHFWS***

2.5.4. Every school must have facilities for Safe drinking water and latrines; proper use of the latrine must be inculcated at the school level.
ACTION: ***DHFWS, Education Department, NGOs.***

2.5.5. Periodic deworming and correction of the Nutritional anaemia (by providing supplementary Iron tablets) for pregnant and lactating mothers, women, children and adults.
ACTION: ***DHFWS, Government (Central and State)***

2.6 NON COMMUNICABLE DISEASES

2.6.1 Diabetes mellitus

2.6.1.1. All PHCs to have facilities to detect and manage / refer patients with Diabetes.
ACTION: ***DHFWS, NGOs***

2.6.1.2. Secondary Care hospitals should have physicians re-oriented for the management of persons with diabetes and their complications together with the needed anti-diabetic drugs, including Insulin.
ACTION: ***DHFWS***

2.6.2 Hypertension and Cardio-vascular Diseases

2.6.2.1. All PHCs to be able to diagnose hypertension and risk factors for cardiovascular diseases and to manage/refer patients, as necessary.
ACTION: ***DHFWS, Professional Bodies***

2.6.3 Mental Health and Epilepsy

2.6.3.1. The Community based Mental Health Programme in Bellary District should be strengthened.
ACTION: ***DHFWS, NIMHANS***

2.6.3.2. Train Primary Care physicians and paramedical workers in the diagnosis and management of epilepsy. Make available the needed drugs (phenobarbitone and phenytoin) without break, through the Primary Health Centres.
ACTION: ***DHFWS, NGOs***

2.6.3.3. Improve the facilities and conditions in the Karnataka Institute of Mental Health, Dharwad which should continue as the major speciality institute with autonomy in governance.
ACTION: ***DHFWS,Government, DME***

2.6.4 Cancer Control

2.6.4.1. Downstaging of Cancer Cervix programme to be initiated on priority.
ACTION: ***DHFWS, KMIO, Government***

2.6.4.2. A model comprehensive Cancer Control Pilot Project to be initiated at Mandya district.
ACTION: ***DHFWS, KMIO***

2.6.4.3. Director, Kidwai Memorial Institute of Oncology, Bangalore to be ex-officio Joint Director (Cancer Control).
ACTION: ***DHFWS, Government***

2.6.5 Oral Health

2.6.5.1. All Taluka hospitals to have qualified dental surgeons.
ACTION: ***DHFWS, Government, NGOs***

2.6.5.2. Principal, Government Dental College to be ex-officio Joint Director (Dental Health).
ACTION: ***DHFWS, Government***

3. Maternal and Child Health

3.1. Increasing the skills of ANMs in the CNA methodology. Revision of the existing training syllabus to incorporate enhanced technical and communication skills. Sensitisation regarding the importance of the timing, spacing and number of births, and exclusive breast feeding for the first 6 months.
ACTION: *DHFWS, PD-RCH*

3.2. The role of Dais in safe deliveries should be supported and training enhanced. Disposable Delivery Kits of good quality cost effective components should be provided.
ACTION: *DHFWS, PD-RCH, Government*

3.3. Where services of ANM are not available, the AWW to be trained to undertake the specified activities till a regular ANM is posted.
ACTION: *DHFWS, PD-RCH*

3.4. To cater to the Newborn Care the Anganwadi worker to be trained to be the second functionary. She may be given additional monetary compensation.
ACTION: *DHFWS, Department of Women and Child Welfare*

3.5. Ensure 100% registration in the first trimester, proper antenatal, natal, and postnatal care with involvement of Private Sector.
ACTION: *DHFWS, NGOs*

3.6. Ensure 24-hour delivery services at FRUs. with involvement of Private Sector.
ACTION: Government, *DHFWS, NGOs*

3.7. Ensure uninterupted supply of IFA at all times at all Health Care Institutions.
ACTION: Government, *DHFWS*

3.8. A Pilot Project has been taken up in the district of Bellary with proactive involvement of FOGSI. The identified FOGSI members would undertake Antenatal Clinics for those at high risk within a radius of 10 Kms from the FRUs, complement the available services in Public Hospitals and also involve in Training Programmes.
ACTION: DHFWS; PD-RCH; FOGSI and VOs

4. Population Stabilisation

4.1. A Population Policy as part of the comprehensive Health Policy will be drafted for wider discussions for eliciting public and professional opinion.
ACTION: Government, *DHFWS, NGOs*

4.2. Commence a strong IEC programme regarding the health hazards and social ills of early marriages, the need to raise the age at marriage and advantages of postponing the second child.
ACTION: *DHFWS, Media(Electronic, Cultural, Print)*

5. Focus on Special groups

5.1 WOMEN AND HEALTH

5.1.1. Sensitise all Health Care Personnel on issues relating to gender inequalities.
ACTION: *DHFWS, NGOs*

5.1.2. Educate and promote personal hygiene especially during menstrual period by the distribution of subsidised menstrual pads/cloth.
ACTION: *DHFWS, NGOs, Government*

5.1.3. Services of Lady Medical Officer to be available at al Primary Health Centres..
ACTION: *DHFWS*

5.1.4. Improve diagnostic, medical and counselling services for STI & HIV/AIDS for women as well as the sexual partner.
ACTION: *DHFWS, SIHFW*

5.1.5. Initiate efforts to identify gender related barriers to TB diagnosis and treatment; integrate into overall efforts to improve programme effectiveness. Identify sources of inequity.
ACTION: *DHFWS, NTI*

5.2 PERSONS WITH DISABILITIES

5.2.1. Utilise Media to create awareness and training of parents and other care-givers on specific disabilities.
ACTION: *DHFWS, NGOs, Media (Print, Electronic, Cultural)*

5.2.2. Reestablish the role of the Health department in Disability Prevention, Early detection, Intervention, corrective surgery and physiotherapy.
ACTION: *DHFWS, Disabled Welfare Department.*

5.3 TRIBAL HEALTH

5.3.1. Strengthen the Mobile Health Units and the PHCs in the Tribal areas and make them all functional.
ACTION: *DHFWS, NGOs*

5.3.2. Initiate a systematic documentation of Traditional Medicine with the help of Voluntary Organisations.
ACTION: ***DHFWS, VOs***

5.3.3. Strengthening of the Tribal ANM project. The current batch of 27 needs to be posted on priority and a fresh batch of training to be initiated.
ACTION: ***DHFWS***

6. Health Education

6.1 HEALTH EDUCATION

6.1.1. Reorganise and integrate the different IEC programmes in the Directorate of Health and Family Welfare Services with professional inputs.
ACTION: ***DHFWS, NGOs***

6.2 SCHOOL HEALTH

6.2.1. Initiate action for greater coverage of all students in all the schools in the state with health (including Dental) checkups and health education. Train students in First Aid.
ACTION ***DHFWS, NGOs***

6.2.2. Use AIR / DD to impart lessons in Health (similar to UGC programmes).
ACTION: ***DHFWS, Media (Electronic), NGOs***

7. Health Human Resources Development

7.1. The issuing of essentiality certificate by the Government and affiliation by the University for new Medical, Dental, Nursing, Pharmacy and Physiotherapy Colleges should be stopped for the next three years, the exception being Nursing Colleges in underserved areas of Karnataka. Where essentiality certificate or temporary affiliation has been given but the College has not started functioning, the certificate and affiliation should be withdrawn immediately.
ACTION: ***Government, DME, RGUHS***

7.2. Extend the moratorium on new Ayurvedic, Homoeopathy and Unani Colleges by another 2 years.
ACTION: ***Government, DME, RGUHS***

7.3. Take up urgently the repairs of the buildings of the Colleges, hospitals and hostels, equipment and vehicles of the Government teaching institutions and hospitals. All equipment must be maintained in good working condition.
ACTION: ***Government, DHFWS, RGUHS, DME***

7.4. Redeploy teaching and non-teaching staff according to the needs.
ACTION: ***DME***

7.5. Streamline the working of emergency services like Casualty, Burns, and Accidents. Round the clock diagnostic (X-ray, laboratory, etc.) and blood bank services in all teaching Hospitals. Essential drugs must be available at all times.
ACTION: ***DME***

7.6. The State Institute of Health and Family Welfare to be upgraded and be made autonomous. The Institute and RGUHS together with VOs and experts should take up the training at all levels in management, public health and ethics.
ACTION: ***Government, DHFWS, SIHFW, RGUHS, VOs, Experts, Task Force***

7.7. Increase the intake for the training of Auxiliary Nurse Midwives (ANMs) Encourage NGOs with the capacity for training to take up the training of ANMs.
ACTION: ***Government, DHFWS, NGOs***

7.8. Every Medical and Dental College to adopt a block for service to the people of the area and training of students.
ACTION: ***Government, DME, DHFWS, RGUHS, All Medical and Dental Colleges***

7.9. Corruption in the examination system to be eliminated.
ACTION: ***Government, DME, RGUHS, All Colleges***

7.10. The teaching programmes in the Government Medical Colleges to be strengthened by invited teaching faculty and given suitable remuneration; they will not have clinical responsibility at the hospital.
ACTION: ***Government, DME, RGUHS***

8. Health Systems Management

8.1 ADMINISTRATION

8.1.1. All administrative posts in the Directorate to be filled up.
ACTION: ***Government, DHFWS***

8.1.2. All the posts of Joint Directors and above to be selection posts.
ACTION: ***Government, DHFWS***

8.1.3. The services of doctors with Postgraduate qualifications in various disciplines serving at different PHCs to be utilised to fill the vacancies at Taluka level and above Health Care Institutions.
ACTION: ***Government, DHFWS***

8.1.4. A Vigilance Cell in the Directorate headed by the Commissioner for disciplinary action against corruption, absenteeism and for speedy disposal of enquiries.

ACTION: ***Government***

8.1.5. The process of regularisation of the contract doctors to be commenced.
ACTION: ***Government, DHFWS***

8.1.6. A transfer Policy to be evolved on the basis of well defined criteria, and implemented. Mis-match of professionals and service requirements to be addressed.
ACTION: ***Government, DHFWS, Task Force***

8.1.7. About 100 Doctors from the Department to be selected through a transparent "search-cum-selection" mechanism assisted by Task Force, given intensive training in management and placed at the Directorate and DHOs Offices as Programme managers.
ACTION: ***DHFWS; SIHFW***

8.1.8. The selection of In-service Doctors for postgraduate courses to be based on the needs of the Department for quality health care.
ACTION: ***DHFWS, Government***

8.1.9. The practice of postings of officers OOD should be kept to the bare essential.
ACTION: ***Government, DHFWS***

8.1.10. The role, responsibility and authority of Commissioner, Health and Family Welfare to be defined enabling to function effectively. Suggestion in Annexure. Sufficient administrative and financial powers to be delegated
ACTION: ***Government***

8.1.11. The system of performance appraisal (confidential reports) to be implemented.
ACTION: ***DHFWS***

8.2 PLANNING

8.2.1. A suitable structure for the Planning Unit in the Directorate, and descriptions of its functions to be prepared to address the issues of long time, 5 year and annual plans, the Physical, Financial and Human resources Plan.
ACTION: ***Government, DHFWS, Task Force***

8.3 FINANCING

8.3.1. Additional resources to be provided during 2000 – 2001 to carry out the reforms suggested.
ACTION: ***Government***

8.3.2. Monitoring of expenditure, especially plan programmes to ensure adequate utilisation and results must be done.
ACTION: ***Commissioner, Health and Family Welfare***

8.4 HEALTH INFORMATION MANAGEMENT SYSTEM

8.4.1. An integrated Geographical Information System based HMIS to be initiated and implemented.
ACTION: ***Government, DHFWS, Task Force***

8.4.2. All the District Health Officer should be computerised for efficient management and control of Health System in the district.
ACTION: ***Government, DHFWS, Task Force***

8.4.3. The formats / registers needed at various levels to be updated, printed and supplied in adequate quantities and on-time.
ACTION: ***DHFWS, Task Force***

8.4.4. Annual reports and monthly updated programme performance to be placed on website of the Directorate.
ACTION: ***Government, DHFWS, Task Force***

8.5 MEDICINES PROCUREMENT AND SUPPLY

8.5.1. The Rate Contract System

(a) to be based on the exhaustive list incorporating the features of the WHO and the National Essential drug list;

(b) if there is no bidder for any essential drug, suitable alternative arrangement to be delineated for purchases to be made.

ACTION: ***Government, DHFWS, Drugs Controller***

8.5.2. The RC should specify the total requirement of the drugs for the entire State including that of ZPs and include all sources and not just 40% of the GMS quota.
ACTION: ***Government, DHFWS***

8.5.3. The ZP or any other drugs procurement agency for Government Health Care Institutions in Karnataka should restrict to the drugs listed in the RC. Exceptions to be made with not greater than 10% of the allocated norm.
ACTION: ***Government, DHFWS, ZP***

8.6 LAW AND ETHICS

8.6.1. The legislation introduced in the Legislative Council to regulate the functioning of Health Care Institutions should be sent to a Select Committee to elicit views from all concerned (stake-holders, professionals and public).
ACTION: ***Government***

8.6.2. Take steps to renew the registration of health professionals once in 5 years with the respective State Councils. Initiate steps to register all Health Care Institutions.

ACTION: ***Government, DHFWS, State Councils for Medicine, Dentistry, Nursing,Pharmacy.***

9. Indian Systems of Medicine and Homeopathy

9.1 AYURVEDA, UNANI AND HOMEOPATHY

9.1.1. Plan and initiate planning to have ISM&H wings in the existing District / Taluka hospitals.
ACTION: ***Government, DHFWS,DISM&H***

9.1.2. The drug licensing authority should ensure the printing of the date of manufacture and date of expiry of drugs on the containers.
ACTION: ***DISM&H, Drugs Controller***

9.1.3. The supply of medicines to hospitals and dispensaries must be quarterly to avoid loss of potency.
ACTION: ***Government, DISM&H***

9.1.4. The budget allocation per dispensary should be increased to Rs. 36,000/- per annum.
ACTION: ***Government, DISM&H,***

9.1.5. The stipend for the Interns and Postgraduates to be enhanced.
ACTION: ***Government, DISM&H***

9.1.6. Steps to be taken to conduct Entrance Tests for selection to Postgraduate courses.
ACTION: ***DISM&H***

10. Panchayat Raj and Empowerment of People

10.1 PANCHAYAT RAJ INSTITUTIONS AND HEALTH

10.1.1. Training must be imparted to the new Panchayat members regarding their responsibilities and duties, with particular regard to health and other social sectors; relationship with the health staff and need for monitoring health programmes to be emphasised.
ACTION: ***NGOs, Government***

10.1.2. Women members of Panchayats should be separately oriented to the RCH, ICDS and similar programmes. They should be motivated to take on the role of community leaders in health and health-related issues.
ACTION: ***Government, DHFWS, ISEC***

10.1.3. The Gram Panchayat should appoint a woman health functionary at Villages, where there is no ANM or Anganwadi worker for the management of Health, Nutrition, Drinking Water and Sanitation, Population. This could be initiated atleast in a few districts where Human Development Index is low.
ACTION: ***Government, DHFWS, RDPR***

10.2 PEOPLES EMPOWERMENT FOR HEALTH

10.2.1. A pilot project in one District to have Health Committees at Village, Sub-centre and Primary Health Centre levels.
ACTION: ***Government, DHFWS, DPRD, NGOs***

11. Strengthening Partnerships

11.1 VOLUNTARY ORGANISATIONS

11.1.1. A Directory of Voluntary Organizations working in Health and Health-related work in Karnataka should be brought out immediately and updated periodically.
ACTION: ***Government, DHFWS,***

11.1.2. Introduce a single window Voluntary Organisations Cell at the Health Directorate to co-ordinate the different programmes and simplifying procedures for grant-in-aid avoiding delays. Commissioner to be the nodal officer.
ACTION: ***Government, DHFWS, NGOs***

11.2 PRIVATE AND CORPORATE SECTOR

11.2.1. Use the services of private practitioners and specialists where there is lack of such personnel in the Government sector, paying for their services on mutually agreed terms. In case of deficiency of doctors in PHCs, Private Practitioners may be appointed on "adhoc" basis.
ACTION: ***Government, DHFWS, NGOs***

11.2.2. Involve organisations of doctors in IEC activities and national programmes.
ACTION: ***Government, DHFWS, NGOs***

11.2.3. Provide drugs and vaccines in the national programmes to the private practitioner for the benefit of the economically poor.
ACTION: ***Government, DHFWS, NGOs***

11.2.4. Tertiary hospitals in Private sectors to also provide training programmes for the government doctors.
ACTION: ***Government, DHFWS, NGOs***

Annexures

ANNEXURE 1A
Government Order appointing the Task Force

Proceedings of the Government of Karnataka

Sub: Constitution of Task Force on Health and Family Welfare – reg.

Ref: Note No SCM / 516 / 99, Dated 10-11-1999

PREAMBLE:

In order to propose measures to improve the public health care system in the State of Karnataka, it has been felt necessary to set up a Task Force, consisting of eminent persons in various fields, which would examine the issues involved and propose measures which could be adopted by Government.

Hence the following order.

Government Order No. HFW 545 CGM 99, Bangalore, Dated 14-12-1999

A Task Force on Health and Family Welfare is hereby set up consisting of the following persons:

1.	Dr. H. Sudarshan, Karuna Trust, B.R. Hills	Chairman
2.	Sri P. Padmanabha, Former Registrar General, India	Member
3.	Dr. Chandrashekar Shetty, Vice Chancellor, Rajiv Gandhi University of Health Sciences	Member
4.	President, Indian Medical Association, Karnataka Branch	Member
5.	Dr. Jacob John, C.M.C., Vellore	Member
6.	Dr. C.M. Francis, Bangalore	Member
7.	Dr. S. Nagalotimutt, Rtd. Director, Karnataka Institute of Medical Sciences (KIMS), Hubli	Member
8.	Dr. Latha Jagannathan, T.T.K. Blood Bank, Bangalore.	Member
9.	Dr. Jayaprakash Narayan, M.D. (Ayurveda), Bangalore	Member
10.	Swami Japananda, Chairman, Swami Vivekananda Interegrated Rural Health Centre, Pavagada, Tumkur	Member
11.	Dr. M. Maiya, Physician, Bangalore	Member
12..	Dr. S. Subramanya, Project Administrator, Karnataka Health Systems Development Project	Member Convenor

The following shall be the Terms of Reference of the Committee:

1. The Task Force shall propose to the Government various policy measures to be adopted for improving the public health care system in the State.

2. The Task Force shall propose measures to stabilize the population at a net reproductive rate of 1 and suggest the time frame by which this should be achieved.

3. The Task Force shall also make recommendations regarding improvements necessary in the management and administration of the Department of Health and Family Welfare for this purpose.

4. The Task Force shall also recommend changes in the education system covering both clinical and public health areas keeping in view the improvements envisaged above.

5. The Task Force shall not only make recommendations with regard to the above issues but is also expected to monitor the impact of the recommendations especially in the initial stages of implementation. Hence the Task Force may set out specific outcomes to be achieved by the Department of Health and Family Welfare after the implementation of the recommendations.

The terms and conditions regarding the sitting fees, etc. are at Annexure-I to this order.

By order and in the name of the
Governor of Karnataka
Sd/-
(SIDDALINGAIAH)
Under Secretary to Government
Health & Family Welfare Department

To,

1. Dr. H. Sudarshan, Karuna Trust, B.R. Hills
2. Sri P. Padmanabha, Former Registrar General, India
3. Dr. Chandrashekar Shetty, Vice Chancellor, Rajiv Gandhi University of Health Sciences
4. President, Indian Medical Association, Karnataka Branch
5. Dr. Jacob John, C.M.C., Vellore
6. Dr. C.M. Francis, Bangalore
7. Dr. S. Nagalotimutt, Rtd. Director, Karnataka Institute of Medical Sciences (KIMS), Hubli
8. The Accountant General in Karnataka, Bangalore
9. The Commissioner, Health & Family Welfare, Bangalore
10. The Director, Health & Family Welfare, Bangalore
11. Dr. Latha Jagannathan, T.T.K. Blood Bank, Bangalore
12. Dr. Jayaprakash Narayan, M.D, (Ayurveda), Bangalore
13. Swami Japananda, Chairman, Swami Vivekananda Integrated Rural Health Centre, Pavagada, Tumkur
14. Dr. M. Maiya, Physician, Bangalore
15. Dr. S. Subramanya, Project Administrator, Karnataka Health Systems Development Project

Copy to:

1. P.A. to Principal Secretary to the Government, Health & Family Welfare Department
2. P.A. to the Deputy Secretary (H), Health & Family Welfare Department

ANNEXURE 1B

PROCEEDINGS OF THE GOVERNMENT OF KARNATAKA

Sub: Constitution of Task Force on Health and Family Welfare – Nomination of additional Members

Read: G.O. NO. HFW 545 CGM 99 dt. 14.12.99

PREAMBLE:

In order to propose measures to improve the public health care system in the State, a Task Force has been constituted vide Government order referred above.

It has been considered necessary to include some more members in the Task Force to represent their respective fields. Hence, the following order.

GOVT.ORDER NO.HFW 545 CGM 99 BANGALORE DT.20.1.2000

In continuation of constitution of Task Force vide Govt. order dt. 14.12.1999, the following additional members are nominated as against their names.

1.	Dr. Kamini Rao, Gynaecologist	Member
2.	Dr. Thelma Narayan, Community Cell, A Health Policy NGO	Member

The terms and conditions regarding the sitting fees etc., are at Annexure – I of Govt. order dt. 14.12.99 remains the same.

By order and in the name of the
Governor of Karnataka
Sd/-
(SIDDALINGAIAH)
Under Secretary to Government
Health & Family Welfare Department

To

1. Dr. H. Sudarshan, Vivekananda, Girijana Kalyana Kendra (Karuna Trust) B.R. Hills-571 441, Yelandur Taluk, Chamarajanagar District
2. Dr.S. Subramanya, Project Administrator, Karnataka Health Systems Development Project, Seshadri Road, Bangalore – 560 001
3. The concerned (through Member Convenor, Task Force, Project Administrator, KHSDP, Seshadri Road, Bangalore – 560 001.
4. The Secretary to the Chief Minister

Copy to:

1) P.S. to Principal Secretary
2) P.A to P.S-1 & 2

ANNEXURE 1C

PROCEEDINGS OF THE GOVERNMENT OF KARNATAKA

Sub: Constitution of Task Force on Health and Family Welfare, reg.

Read: 1) G.O. NO. HFW 545 CGM 99 dt. 14.12.99 and 20.1.2000
2) Notification No. DFAR 133 CAS 2000 dt. 6.3.2000

PREAMBLE:

In the Government order read at (1) above, sanction was accorded to set up a Task Force on HFW Department consisting of 12 eminent persons and with Dr. S. Subramanya Project Administrator, KHSDP, Bangalore as Member Convenor.

In the Notification read at (2) above on returing from leave Dr. S. Subramanya is transferred and appointed as Secretary to Government (Mines, SSI & Textiles) Commerce and Industries Department, Bangalore and Sri. Arvind G Risbud is appointed as Project Administrator, Karnataka Health System Development Project and Special Secretary to Government, Health & Family Welfare Department, Bangalore, Vice Dr. S. Subramanya IAS transferred.

Now, it is considered necessary to appoint nominate Sri Arvind G Risbud as Member Convenor of above said Task Force with immediate effect and until further orders.

Government Order No. HFW 545 CGM 99, BANGALORE DT. 16.3.2000

In the circumstances explained above, Government are pleased to nominate The Project Administrator, Karnataka Health System Development Project and Special Secretary to Government, Health and Family Welfare Services Department as Member Convenor of Task force of Health & Family Welfare Department, with immediate effect and until further orders.

The other conditions mentioned in the said Government Order small remain unaltered.

By order and in the name of the
Governor of Karnataka
Sd/-
(SIDDALINGAIAH)
Under Secretary to Government
Health & Family Welfare Department

To:

1. Dr. H. Sudarshan, Karuna Trust, B.R. Hills
2. Sri P.Padmanabha, Former Registrar General, India
3. Dr. Chandrashekar Shetty, Vice chancellor, Rajiv Gandhi University of Health Sciences, B'lore.
4. President, Indian Medical Association, Karnataka Branch
5. Dr. Jacob John, C.M.C., Vellore
6. Dr. C.M. Francis, Bangalore
7. Dr.S. Nagalotimath Rtd. Director, Karnataka Institute of Medical Sciences (KIMS) Hubli

8. The Accountant General in Karnataka, Bangalore
9. The Commissioner, Health & Family Welfare, Bangalore
10. The Director, Heath & Family Welfare, Bangalore
11. Dr. Latha jagannathan, T.T. K. Blood Bank, Bangalore
12. Dr. Jayaprakash Narayan, M.D. (Ayurveda), Bangalore
13. Swami Japananda, Chairman, Swami Vivekananda Integrated Rural Health Centre. Pavagada, Tumkur
14. Dr. M. Maiya, Physician, Bangalore
15. Dr.S. Subramanya, Project Administrator, Karnataka Health Systems Development Project, Seshadri Road, Bangalore.

Copy to:

1. P.S to Principal Secretary to the Govt. HFW dept.
2. P.A. to DS-I-II, HFW Dept.

ANNEXURE 2

Schedules of the Meetings and Consultations (Entire Group)

Month	Dates
1. December 1999	21st
2. January 2000	3rd, 4th, 5th, 10th, 11th, 12th, 27th, 28th, 29th
3. February 2000	8th, 14th, 15th, 16th, 21st, 25th, 28th, 29th
4. March 2000	1st, 6th, 7th, 8th, 11th, 13th, 20th
5. April 2000	6th, 14th

Total = 28 full working days.

ANNEXURE 3

Sub Groups and Members

	TOPICS	MEMBERS
A.	Health Systems and Services in Rural Areas. Health Systems and Services in Urban Areas. Emergency Health Care. Panchayat Raj and Health Care.	Dr. C. M. Francis (Team Leader) Sri. P. Padmanabha. Dr. M. Maiya. Swami Japananda.
B.	Communicable Diseases.	Dr. Jacob John. (Team Leader) Dr. Latha Jagannathan. Dr. S. Nagalotimath. Swami Japananda.
C.	Population Stabilisation (RCH).	Sri. P Padmanabha. (Team Leader) Dr. Latha Jagannathan. Dr. Suresh. B. Kulkarni.
D.	Human Resource Development Medical Education. Health Education.	Dr. Chandrashekar Shetty(Team Leader). Dr. C. M. Francis. Dr. Jacob John. Dr. S. Nagalotimath.
E.	Health Financing.	Sri P Padmanabha (Team Leader). Dr. S. Subramanya.
F.	Indigenous / Alternate Systems of Medicine.	Dr. Jayaprakash Narayan. (Team Leader) Dr. Chandrashekar Shetty.
G.	Non Communicable Diseases, Dental Health, Mental Health and Epilepsy.	Dr. S Nagalotimath(Team Leader). Dr. C. M. Francis.
H.	Nutrition.	Dr. C M Francis (Team Leader). Dr. P. Padmanabha.
I.	Health of Special Groups.	Dr. Jacob John. Dr Latha Jagannathan(Team Leader)
J.	Voluntary Sector in Health Care.	Swamy Japananda (Team Leader). Dr. Chandrashekar Shetty. Dr. M. Maiya.
K.	Private / Corporate Sector in Health Care.	Dr. M. Maiya. (Team Leader) Dr. Suresh. B. Kulkarni. Dr. Latha Jagannathan.
L.	Law and Ethics.	Dr. C. M. Francis(Team Leader) Dr. Latha Jagannathan.
M.	Health Policy. Inter Sectoral Co-ordination. External aided Projects.	Dr. C. M. Francis. (Team Leader) Dr. Thelma Narayan
N.	Health Management Information Systems.	Dr. Latha Jagannathan (Team Leader). Sri. P. Padmanabha.
O.	Administration and Planning	Sri P Padmanabha
P.	Maternal and Child Health	Dr. Kamini Rao (Team Leader). Dr. Thelma Narayan Dr. Lata Jagannathan

ANNEXURE 4

List of Individuals / Organisations / Associations who interacted with the Task Force

Ministry of Health, Government of Karnataka

1. Dr. Maalaka Raddy, Honourable Minister of Health and Family Welfare
2. Smt. Nafees Fazal, Honourable Minster of State for Medical Education
3. Sri Abhijit Sen Gupta, IAS Principal Secretary,
4. Sri A K M Nayak, IAS Formerly Health Commissioner
5. Sri Sanjay Kaul, IAS Health Commissioner
6. Sri Jyothi Ramalingam, IAS Formerly Medical Education Secretary
7. Sri. Thangaraj D, IAS Medical Education Secretary
8. Dr. Subramanya S, IAS Formerly Project Administrator, KHSDP
9. Sri Arvind G Risbud, IAS Project Administrator, KHSDP
10. Sri Shivasailam, IAS Formerly Project Director, IPP IX
11. Sri. Sadashiviah, IAS Project Director, IPP IX

Directorate

Health and Family Welfare Services:

1. Dr. P N Halagi, Director of Health and Family Welfare,
2. Dr. Makapur, Director, State Institute of Health and Family Welfare
3. Dr. Shivaratna Savadi, Formerly Director of Medical Education
4. Dr. Nagaraj G V, Project Director, RCH
5. Dr. Murugendrappa, Additional Director, Primary Health
6. Dr. Kurthkoti, Additional Director, Health Education and Training
7. Dr. K. Sharadamma, Additional Director (SPC), KHSDP
8. Dr. Bhattacharjee, Director, Population Centre
9. Dr. Kumaraswamy, Joint Director, Ophthalmology
10. Dr. Janguay, Joint Director, Leprosy
11. Dr. Narayana Murthy, Joint Director, Tuberculosis
12. Dr. Jayadev, Joint Director, HET
13. Dr. Jalaja Sundaram, Joint Director, Nutrition
14. Smt. H.S. Susheela, Joint Director (IEC)
15. Sri Prakasham, Joint Director, Demography
16. Dr.V. S. Rajamma (HMIS), Deputy Director, KHSDP
17. Dr. K R Kamath, Deputy director, PHI
18. Dr. M. Dhananjaya Reddy (CMD), Deputy Director
19. All the District Health Officers
20. All District Surgeons
21. Dr. D.M. Koradhanyamath, Training Officer, IPP-IX
22. Shri P. Mahadev, Asst. Leprosy Officer,
23. Smt. D. R. Jayashri, Systems Analyst,
24. Sri Veeranna, Assistant Director, Nursing Services

Indian Systems of Medicine and Homoeopathy

25. Dr. S M Angadi, Director of Indian Systems of Medicne,
26. Dr. Malini, Principal, Government Ayurvedic College,
27. Dr. Prakash, Principal, Government Homeopathic Medical College

Drugs Control Department

28. Dr. Ananada Rajashekar, Drugs Controller
29. Mr. Prabha Chandra, Deputy Drugs Controller
30. The Chief Pharmacist, Government Medical Stores

3] **Bangalore Mahanagara Palike**

1. Dr. Siddegowda, Health Offcier, Bangalore Mahangara Palike
2. Dr. M. Jayachandra Rao, Project Director, IPP 8
3. Dr. Mala Ramachandran, Programme Officer (Health and Administration), IPP8

4] **Professional Bodies**

1. Dr. Chikkananjappa, Karnataka Medical Council
2. Dr. K B Naggor, Dr. Hanumegowda, Karnataka Council for Indian Systems of Medicine and Homeopathy
3. Smt. Sunitha Srinivas, Deputy Director, Drug Information Centre, Pharmacy Council
4. Dr.V. Brahmacharya, President, Homeopathic Board
5. Representative, Karnataka Dental Council

6. Dr. Ramesh Bilimagga, Dr. Sheela Bhanumathy, Dr V C Shanmuganandan, Indian Medical Association
7. Dr. Mallikarjunaiah, Dr. Shantaraj, Dr. Hanumanthrayappa, Karnataka Government Medical Officers Association
8. Dr. Shivananda, Dr. R Chandrashekara, Dr. Narasimhaswamy K R, Karnataka Government Medical and Dental Teachers Association
9. Dr. C. Muralidhar, President, Ayurvedic Physicians Association
10. Dr. K.C. Ballal, Dr. C. Muralidhar, Dr. K.V. Joshi, Dr. L.K. Rauannavar, Dr. J. Aprameya raman and Dr. Padmanabha, Integrated Medicine Practitioners Association
11. Dr. Nityananda, Dr. Srinivas D R, Junior Doctors Association
12. Dr. Malikarjuna R, Dr. Veerabhadraiah, Dr. Sanath Kumar, Dr. Ravishankar, Karnataka Government Contract Doctors Association

Voluntary Organasations

1. Dr. Jayashree Ramakrishna, AIDS Forum Karnataka
2. Smt. Neerajakshi T, Voluntary Health Association of Karnataka
3. R. Balasubrammaniam, Swami Vivekananda Youth Movement
4. G. Mallappa, Folk Practioner
5. Dr. Shobha Yohan, Christian Medical Association of India, Karnataka
6. Sr. Elise Mary, Catholic Health Association of India, Karnataka
7. Dr. Ravi Narayan, Community Health Cell
8. Sri Jayakumar Anagol, SOSVA
9. Sri Auxin Thomas, FEVORD (K)

National Institutes and Premier Institutions

1. Mrs. Dr. Jogota The Director National Tuberculosis Institute
2. Dr. Mohan Issac, Prof & Head, Dept. of Psychiatry
3. Dr. Shastry, Neuro Surgeon & HOD of Neuro Surgery, NIMHANS
4. Dr. Nagaraj C, Regional Office of Health and Family Welfare
5. Dr. H. R. Raj Mohan, In-Charge Director, Regional Occupational Health Centre.
6. Dr Raju and Dr Rayappa, Institute of Social and Economic Change,
7. Dr. Shymal Biswas, I/c, Director National Institute of Communicable Disease
8. Dr. Prasanna, The Office-in-Charge, National Institute of Virology
9. Dr. Ghosh, The Regional Director, Malaria Research Centre
10. Dr. Nanda Kumar, Project Officer, National Cancer Registration Prg

Outside the health Sector

1. Sri M Jothi, Director, Department of Agriculture
2. Sri Krishna Kumar IAS, Principal Secretary, Urban Development
3. Sri G V K Rao IAS, Food and Civil Supplies
4. Smt Meera Saxena IAS, Women and Child Development
5. Smt Anita Kaul, IAS, Education
6. Sri Ganjigatti, Member secretary, Karnataka State Pollution Control Board
7. Dr. Sharma, Regional Director, Central Pollution Control Board
8. Sri Krishna Murthy. H.V, Song and Drama Division, Government of India

Interaction with Press

1. Sri Chennakrishna, Reporter, Samyukta Karnataka
2. Sri. G.D. Yatish Kumar, Reporter, Janavahani
3. Sri. B. S. Satish Kumar, Deccan Herald
4. Reporter, Asian Age
5. Smt. Padmini, The Hindu
6. Sri B N Chandrakumar, Programme Officer, Doordarshan Kendra

Health Organisations

1. Sri G.S. Bhatt, Family Planning Association of India, Mysore
2. Mr. Raj Mathur, Family Planning Association of India, Bangalore
3. Mrs. Subhadra Venkatappa, Family Planning Association of India, Bangalore
4. Mr. Muniswamy, Family Planning Association of India-Bangalore

Citizens / Consumer Groups

1. Mr. Leo Saldhana, Environment Support Group
2. Ms Vijaya, CIVIC
3. Mrs Anjana Iyer, Mr. Govardhan and Mrs Sheela Prema Kumar, SWABHIMANA.
4. Mr. Surya Shetty, Mangalore Parisarasaktha Okkuta
5. Y.G. Muralidhar, Consumer Rights Education and Awareness Trust.

Women's Group

1. Ms Ruth Manorama and Mrs Shan Taj, National Alliance of Women, Women's Voice
2. Mrs. Prema David, Ms Padma Priya, Vimochana
3. Mr. Vimalanathan, NESA
4. Mrs. Anitha Reddy, AVAS

Peoples Organisations

1. Sri Sridhar and Sri Basavaraju, Bharatiya Gnana Vignana Samiti

Corporate Bodies

1. Mr. Tallam Venkatesh, Federation of Karnataka Chamber of Commerce and Industry
2. Dr. Subbaswami and Sri Jatish N. Sheth, Karnataka Drugs Pharmaceuticals Manufactures Association

Voluntary, Private and Corporate Hospitals

1. Dr. Pankaj Mehta, Manipal Hospital, Bangalore
2. Dr. K.S. Shekar and Dr. Shiva Prasad, Bangalore Hospital, Bangalore
3. Dr. Devi Shetty and team, Manipal Heart Foundation, Bangalore
4. Dr. Diwakar and Dr. Hema Diwakar, Diwakar's Hospital, Bangalore
5. Sri P.K. Davison, WOCKHARDT Hospital, Bangalore
6. Dr. P R Desai, Dr. Chikkananjappa, Association of Private Hospitals and Nursing Homes, Karnataka,
7. Dr. Nandini Mundkur and Sri S Akbar Basha, Bangalore Childrens Hospital and Research Centre

Teaching Hospitals

1. Dr. M.R. Sandhya Belwadi, M S Ramaiah Medical Teaching Hospital, Bangalore
2. Dr. Chikka Moga, Victoria Hospital
3. Dr. Chandramma, Bowring and Lady Curzon Hospital
4. Dr. Anil Hegde, St. John's Medical College, Bangalore

Autonomous Hospitals

1. Dr. Ballal, Sanjay Gandhi Accident Relief and Rehabilation Center
2. Dr. Benakappa, Indira Gandhi Institute of Child Health

Invited Guests / Experts

1.Dr. Phadke, St. John's Medical College Hospital, FORTE
2.Dr. Philip Thomas, St. John's Medical College Hospital, FORTE
3.Dr. Venkatesh, Bangalore Kidney Foundation.
4.Sri. D.K. Bhatt, Consultant Health System Management
5.Sri. P.V. Bhat, Principal System Analyst; Smt. K. Padmavathi, Secretary Systems Analyst, National Informatics Centre

6.Sri Manjot Deol, Manager, Sri S Mani, Business Manager; Sri Sanjeev, Vice President, Wipro GE Medical System
7.Justice D.M. Chandrashekar
8.Dr. Hema Reddy, Formerly Director of Health Services
9.Dr. Vinod Vyasulu and Dr. Indira, Centre for Budget and Policy Studies
10. Dr. Sathyanarayana, Centre for Symbiosis of Technology, Environment and Management
11. Dr. Darshan Shankar, Foundation for Revitalisation of Local Health Tradition
12. Dr. R.M. Varma, Consultant Neuro Surgeon
13. Dr. R L Kapoor, Consultant Psychologist
14. Sri P G R Sindhia, MLA and Formerly Health Minister of Karnataka
15. Sri Suryanarayana Rao, Trade Union Leader, CPI (M)
16. Sri Nagaraj G N, Secretariat member, CPI (M),

17. Dr. N.H. Antia, The Foundation for Research in Community Health, Pune
18. Dr. Rajaratnam Abel, RUSHA, Christian Medical College and Hospital, Tamil Nadu
19. Dr. Muraleedharan, Indian Institute of Technology, Chennai
20. Dr. Sridhar, SEWA, Wardha
21. Dr. Almas Ali, Project Officer, South Asia Poverty Alleviation Programme, UNDP
22. Sri Srinivasan, Formerly Health Secretary, Government of India

ANNEXURE 5
List of Invited Suggestions / Comments

Invitations sent to

A]

All the members of the

- The Karnataka Legislative Assembly
- The Karnataka Legislative Council

B]

- The Health Secretaries of the States and Union Territories in India

C]

All the

- District Health Officers, Directorate of Health and Family Welfare Services, Government of Karantaka
- Taluka Health Officers, Directorate of Health and Family Welfare Services, Government of Karantaka
- District Surgeons, Directorate of Health and Family Welfare Services, Government of Karantaka

D] Citizens who responded to the request

Sri Kariyanna,	MLA and Chairman, Scheduled Castes and Scheduled Tribes Welfare Committee
Sri. Chaluvarayaswamy N	Member, Karanataka legislative Assembly Nagamangala
Sri. ChikkamadaNayaka	Member, Karanataka legislative Assembly Bannur
Sri. NeelakanthaRao Deshmukh Garmpalli	President, Zilla Panchayat, Gulbarga
Dr. R Srinivasa Murthy	Professor of Psychiatry, NIMHANS
Dr. Vasundhara M K	Professor and Head of Community Medicine, Dr. B R Ambedkar Medical College
Dr. Mani K S	Formerly Director, NIMHANS
Dr. Munichoodappa C	Consultant Diabetologist, Bangalore
Dr. Parameshwara V	Consultant Physician and Cardiologist, Bangalore
Dr. Hegde B M	Vice-chancellor, Manipal Academy of Higher Education
Dr. Basappa K	Professor of Preventive and Social Medicine and formerly Dean,
Dr. Pruthvish S	Co-ordinator, Disability Training and Research Unit, ACTIONAID- India
Dr. Shivaram C	Emeritus Professor in Community Medicine, M S Ramaiah Medical College
Dr. Nagesh	Principal, R V Dental College
Dr. Rama Rao S V	Consultant in Health
Dr. Ramakrishna V	Health Education Consultant, IUPHE
Prof. Joga Rao S V	Director, TILEM, National Law School of India University
Dr. Sudarshan M K	Professor and HOD, Community Medicine, KIMS

Sri A N Yellappa Reddy	Formerly Secretary to Government of Karnataka
Sr. Anne Marie	Principal, College of Nursing, St. Martha's Hospital
Mrs Sudha Tewari	Managing Director, Parivar Sewa Sanstha, New delhi
Dr. N Shantaram	President, Karnataka Association of Community Health
Dr. Padma Rao	Kasturba Medical College, Manipal

ANNEXURE 6a
List of Suggestions by Post Kannada

Name of the Individual	Organisation	Place
1. Abdul Mujeeb S		Tumkur
2. Administrative Medical Officer	General Hospital, Soraba	Shivamogga
3. Anjanappa		Bangalore
4. Anonymous		Bangalore
5. Anonymous		Bangalore
6. Asthulekhan E Lodi		Gadag
7. Dr. bi. Ashoka Reddy	Karnataka State Government Doctor's Association ®	Chitradurga
8. N.Y. Badager		Belgaum
9. Bahubali		Belagaum
10. Banada S S		Bidar
11. Basava Raju		Tumkur
12. Bhat G S	FPAI	Mysore
13. Dr. Chandrappa Gowda		Shivamogga
14. Chandrika S Y		Davanagere
15. Dakappa Muddhol		Belagaum
16.	District Health and Family Welfare	Chamarajanagar
17. Deputy Medical Director	District Cholera Controlled Team	Gulbarga
18. Dr. Dharwad S C	District Malaria Office	Dharwad
19. Eerappa M Hulihalli		Haveri
20. Guruswamy		Bellary
21. Health Officer	*Mobile Doctor's Unit	Kollegal
22. Heggade V S	Taluka Industrial Centre	Bidar
23. Hony Secretary	Teachers Association, Government Polytechnic	Bidar
24. Kaashivappa A Thotagi		Belagaum
25. Karyadarshi	Taluk Soliga Abhivruddi Sangha (Regd.)	Chamarajanagar
26. Keshvappa M G		Shivamogga
27. Krishnamurthy B R		Bangalore
28. M.D. Krishnayya	Karnataka State Yaadhava Vani Sangha	Bangalore
29. Dr. Kulakarni S S		Belgaum
30. Kumari Shwetha M Revalkar		Davanagere
31. Laksmana Rao T K		Bangalore
32. Dr. M B Rudrappa	Health and family Welfare Training Centre	Hubli
33. Mahadeva Shetty K M		Mysore
34. Dr. S.B. Maheshwara	Dudee Organisation for Rural Reconstruction (Regd.)	Gundlupet
35. Dr. Muralidhar	Karnataka State Government Indian Health and Homoeopathy Contract Doctor's Association (Regd.,)	Bellary
36. Nagappa R Tiger	Karnatak Dalita Sangharsha Samiti	Gulbarga
37. Nagaraja. A	*Jai Bheem Youth Union (Regd)	Bangalore
38. M.S. Nagaraj	Karnataka State Pharmacist's (Allopathy) Association	Bangalore

List of Suggestions by Post Kannada *(continued)*

39. Nanjundaiah	FEDINA - VIKASA	Mysore
40. Nataraj	Sri Guruboodhi Swamigala Vidhyathi Nilaya	Hunusur
41. Nirvani Gowda		Hassan
42. Patil N S and 40 others	Chalakulu, Mattanuru, Malkarna and Shosa	Belgaum
43. Smt. Philomena Joy	Rural Literacy and Health Programme	Mysore
44. Prabhakar N P		Bidar
45. Prabhakar Rao and 6 others		Bidar
46. Dr. Raju		Shivamogga
47. Ramachandra I. Pavar		Belagaum
48. Dr. Ramachandra K.		Mandya
49. Dr. S B Maheshwara.	Dudee Organisation for Rural Reconstruction	Gundlupet
50. Sanga N R		Bagalkot
51. Dr. Sangamesh Kalahal	Karnataka State Govt. Indian Systems' Medical Officers' Association	Bangalore
52. Sattar S A and 6 others		Bhalki
53. Secretary	Taluk Soliga Abhivridhha Sangha	Kollegal
54. Seetharamaiah and Dasegowda	Government Nurses Association, Karnataka	Bangalore
55. Shashikala		Belagaum
56. Shabbir Ahmad Athaar		Gokak
57. Shena Shetty	Aadhivaasi shikshana kendra	Bantwal
58. Sidharameshwar Guruji	Revansidheshwar Prasanna Education Society	Bidar
59. Sidheshwaran G.N.	Chitradurga District Health Supervisor Association	Chitradurga
60. Srinath. N. Navale		Belgaum
61. Dr. P. S. Upaadhyaaya	Taluka Medical Office	Shivamogga
62. H. Venkataramanayya	Shri venkateshwara kendra Trust ®	Bangalore
63. Sheena Shetty	Adivasi Sikshana Kendra	Bantwala
64. Shettar M S		Gadag
65. Siddappa Haralenneyavar		Kunsi
66. Siddarameshwara Guruji	Revanasiddeshwara Prasanna Education Society	Bidar
67. Siddramappa and 20 others	Ajjampura, Singtagere, Sakhrayapatna	Chikkamagalur
68. Dr. P.K. Srinivas	District Malaria Officer	Mysore
69. Srinivas Murthy		Bangalore
70. Subramanya R		Bangalore
71. Subramanya R		Bangalore
72. Taluka Health Officer,	General Hospital	Chintamani
73. Taluka Health Officer		yadhagiri
74. The President	RamaMurthynagar Welfare Association	Bangalore
75. Thimmiah H D		Chitradurga
76. ThyaraMallesh S M		Chitradurga
77. Venkatesh K R	K R Pete General Hospital	Mandya
78. Venkatesh R		Bangalore
79. Verrabhadrappa H		Bhadravathy
80. Vijayalakshmi Yella		Chitaguppa
81. Dr. Yamanur Saheb B P	Karnataka Rajya Nadaf / Pingara Sangha	Bellary
82. G.R. Yogendra Nayak		Shimoga
83.	Taluka Health Officer,	Udipi

84. Dr. R Venkatesh		T Narsipura
85. Smt Vatsala	C/o T S Sridhar	Yelahanka
86. Dr. M Chandrashekar	Ex Chief Judge	Mangalore
87.		

ANNEXURE 6b

List of Suggestions by Post English

Name of the Individual	Organisation	Place
1. Anonymous		Bangalore
2. Justice Avadhani K K		Uttar Kannada
3. Mrs Banerjee		Bangalore
4. Dr. N.D. Bendigeri	Associate Prof. K.I.M.S.	Hubli
5. E. Basavaraju	Bharath Gyan Vigyan Samithi	Bangalore
6. Dr.Chandrashekar N M .	Homepathic Forum	Bangalore
7.	DHO, Health & Family Welfare Dept.	Bangalore
8. Farooqui M A H		Belgaum
9. Ganagmalliah		Bangalore
10. Giri A T S	Bangalore City District Youth Congress (I)	Bangalore
11. Dr.Govindaraju	K R Hospital	Mysore
12. Guttal M C	Directorate of Health and Family Welfare services	Bangalore
13. Dr.Hanumanthappa T.		Chinakurali
14. Health Officer	PHC	Shimoga
15. The Head Master	Manikappa Bandeppa Khashapura Higher Primary and High School	Bidar
16. Dr.Jayanth G Paraki.		
17. Dr.K Taranath Shetty	NIMHANS	Bangalore
18. Krishna Murthy G		Bangalore
19. Kumari Sandhya		Bangalore
20. G.Krishna Swamy	President, Garuda Seva Samaj	Bellary
21. M H Baig Dr.	District Hospital	Bidar
22. Dr.Mahendranath K M	Indian Rheumatism Association, Karnataka State	Bangalore
23. Dr.Maliyappa G H	Shoba Nursing Home	Arsikere
24. Dr.Marekannavar S N		Mysore
25. Murthy S N S	HAL II Stage Civic Amenities and Cultural Association	Bangalore
26. Narayana H S		Bangalore
27. Mrs Nassema Banu	Government Urdu Middle and Higher Primary School	Tumkur
28. Dr.Prakash C Rao	Drugs Action Forum, Karnataka	Bangalore
29. Rangaswamy K.L.		Bangalore
30. Rajanna N	Formerly Member, Karnataka Legislative Assembly	Bangalore
31. Rajarama K E T	Population Research Centre	Dharwad
32. Rajesh		Humnabad
33. Dr. S.V. Rama Rao	Prof. of Community Medicine & Director (Rtd.)	Bangalore
34. Ramesh Kumar Pande	Member, Karnataka Legislative Assembly	Bidar
35. Dr.Ranganath T		Mysore
36. Reddy C R		Bidar
37. Roy David V S	Coorg Organisation for Rural Development	Kodagu
38. Sagar K S	Citizens Forum	Bangalore

List of Suggestions by Post English *(continued)*

39. Sangeeta C M		Humnabad
40. Dr.Sanjeevi Shayana		Raichur
41. Shakeel Ahmed		Tumkur
42. Sharshchandra H D		Bangalore
43. Dr.Shivarama Shastry	PHC Savalanga	Dhunnali
44. Shivasharanappa Chitta	Akkamahadevi Womens College	Bidar
45. Srinath P L		Mysore
46. Srinivasa Rao		Mysore
47. Students	Diploma Physiotherapist Youth Forum	Bangalore
48. Dr.Sumanth Goel		Bagalkot
49. Dr.UdayaKumar		Bangalore
50. Varadaraj B K		Bangalore
51. Dr. U.S. Vanahalli	President, Dr. Hahnemann's Rural Homeo Medical Practitioner's Associtation ®	Mahalingpur
52. Venkatesh		Chamarajanagar
53. Vishwanath Ashturey and others		Bidar
54. Dr. R.S. Wali	Assoc. Prof., B.L.D.E.A's Medical College	Bijapur
55. Yogesh G		Bangalore
56. Ziauudin Alvi		Bidar
57. Dr. Jagadish	CEO, Consulting Engineering Services India Ltd.	
58. Dr. Shashikala M	Community health Specialist, ST Marthas Hospital	
59. Dr. M B Rudrappa	Epidemiologist, Health and Family Welfare Training Centre,	Hubli
60. Dr. B T Basanthappa	Professor, Government College of Nursing	Bangalore
61.	Dy Chief Medical Officer, CHC	Mulki
62. Dr. B N Brahmacharya	Hony Secy. Prakruti Jeevana Kendra ® Trust	Bangalore
63. Dr. Ramkrishna B Goud,	PG in Community Medicine, MSRMC	Banglore

ANNEXURE 7

Suggested Role and Responsibilities of the Commissioner (Health and Family Welfare)

Commissioner (Health and Family Welfare) shall be responsible for monitoring, supervising and implementing all National and State Health and Family Welfare programmes in the State. He shall also perform coordinating functions among the various directorates and divisions both within the Health System as well among related departments.

In specific terms, Commissioner (HFW) shall

1. monitor and supervise the implementation of RCH, National Health Programmes of TB control, Blindness control, Leprosy eradication, Anti Malaria, Women's Health, and such other programmes as Government may determine from to time;
2. coordinate health related programme activities with the Directorate of Medical Education, Drug Controller, Indian Systems of Medicine, as also with the Directorate of Women and Child Development, Commissioner for Public Instruction, and the Directorate for Disabled Welfare; and Urban local bodies:
3. ensure proper integration and coordination in respect of various divisions within the Department of Health and Family Welfare including with the externally assisted project divisions;
4. facilitate the designing and implementing of a convergent MIS for the Health System as a whole;
5. prepare sustainability plans for the externally assisted projects as well as prepare projects for future external funding;
6. guide to prepare all policy and plan-proposals relating to health and family welfare before their submission to Government;
7. be responsible for matters relating to cadre and recruitment rules in respect of personnel of the health and welfare department and look after all correspondence in the Directorate of Health and Family Welfare with Government in respect of posting and disciplinary matters of Class 1 officers;
8. shall serve as a member on all State programme implementation Committees, as well as a member on the Governing Councils of the autonomous health institutions.
9. help the Task Force and the Department in the preparation of a ten year perspective plan for the department taking into consideration appropriate parameters so as to ensure that health services are maintained at an optimum level of adequacy and efficiency.

In addition, Commissioner (HFW) shall perform all functions and discharge such duties and responsibilities as may be assigned to him by Government from time to time.

ANNEXURE 8

Information on Karnataka

HDI and GDI Ranks for Major States:

State	HDI	GDI
Kerala	1	1
Punjab	2	4
Maharashtra	3	2
Haryana	4	9
Gujarat	5	3
West Bengal	6	7
Karnataka	**7**	**5**
Tamil Nadu	8	6
Andhra Pradesh	9	8
Assam	10	10
Orissa	11	11
Rajasthan	12	13
Bihar	13	14
Madhya Pradesh	14	12
Uttar Pradesh	15	15

Source: A K Shivakumar (1991-92) quoted in Human Development in Karnataka, 1999 pp 12

Karnataka – A comparison

Particulars		Karnataka	Andhra Pradesh	Kerala	Tamil Nadu	All India
Average Rural Area (Sq. KM) covered by a	Sub Centre	23.03	25.54	6.97	14.27	22.89
	PHC	117.13	202.18	36.98	86.27	136.22
	CHC	774.88	1303.93	443.76	1720.58	1,154.82
Average Radial Distance (KM) covered by a	Sub Centre	2.71	2.85	1.49	2.13	2.70
	PHC	6.10	8.02	3.43	5.24	6.58
	CHC	15.70	20.37	11.88	23.40	19.17
Average Number of Villages covered by a	Sub Centre	3.32	2.52	0.27	1.82	4.29
	PHC	16.91	19.91	1.44	11.02	25.54
	CHC	11.84	128.43	17.30	219.75	216.53
Number of Sub Centres per PHC		5.09	7.92	5.31	6.05	5.95
Number of PHCs per CHC		6.62	6.45	12.00	19.94	8.48
Number of MPW (M) Per HA (M)		5.0	5.3	3.9	1.3	3.3
Number of MPW (F) per HA (F)		8.1	7	5.3	6	6.9
Average Rural Population (1991) covered by a MPW (F) / ANM		3,837	4466	4748	4305	4,707

Source: Rural Health Statistics in India , June, 1998: Bureau of Health Intelligence, Government of India

RURAL HEALTH Infrastructure in Karnataka:

Health Centres	1999-2000 (upto Dec 99)
Community Health Centres	249
Primary Health Centres	1676
Primary Health Units	583
Sub-centres	8143
Beds	16212

Source: Annual Report, 1999-2000, Department of Health and Family Welfare, Government of Karnataka

URBAN HEALTH Infrastructure in Karnataka:

Hospitals	Institutions (number)	Beds
District Hospitals	24	7616
Teaching Hospitals	9	5907
Major Hospitals	8	1521
Specialised Hospitals	16	3330
General Hospitals / Maternity Hospitals	120	4899
Total	**177**	**23273**
Urban Primary Health Centres	9	54

Source: Annual Report, 1999-2000, Department of Health and Family Welfare, Government of Karnataka

Some selected Health Indicators of Karnataka – a comparison:

Parameter		Karnataka	HFA /2000	All India
Crude Birth Rate		22.0[1]	21	25.9[1]
Crude Death Rate		7.6[1]	9	8.7[1]
Infant Mortality Rate		58.0[1]	60	63.0[1]
Total Fertility Rate		2.8[2]	-	3.2[2]
Effective Couple Protection Rate (%)		58.3[1]	60	45.8[3]
Annual Growth Rate (%)		1.4[1]	-	1.7[1]
Life Expectancy at Birth	Male	61.7[1]	-	62.4[1]
	Female	63.5[1]	-	63.4[1]

1= 1998; 2= 1994; 3= 1995

Source: Annual Report, 1999-2000, Department of Health and Family Welfare, Government of Karnataka; Handbook of Statistics,