KARNATAKA

TOWARDS EQUITY, INTEGRITY AND QUALITY IN HEALTH

Focus on
Primary Health Care
and
Public Health

SUPPLEMENT TO THE FINAL REPORT
VOLUME - I

APRIL 2001

TASK FORCE ON HEALTH AND FAMILY WELFARE
GOVERNMENT OF KARNATAKA
PHI Building, Sheshadri Road,
Bangalore 560001.
Ph: 2271021, email: khsdp@vsnl.com

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VOLUME – I

To be added

RN 11/7/2016

VOLUME – II

1. ACKNOWLEDGEMENTS

1.1 This study is funded by World Bank aided Karnataka Health Systems Development Project (KHSDP) for the Task Force on Health – Government of Karnataka. We would like to express our sincere thanks and appreciation for the support and constant guidance provided at various stages of the study.

1.2 In particular, we would like to thank Dr. H. Sudarshan, Mr. P.Padmanabha IAS (Retd) and Dr. C.M.Francis for their valuable guidance, comments and suggestions during the study.

1.3 We are grateful to Mr. Arvind Risbud, IAS, Project Director- KHSDP & his staff for giving us an opportunity to carry out this study for the Task force on Health by funding and providing us with valuable data.

1.4 We are indebted to Dr. G.V.Nagaraj – Director of Health Services and his entire staff at the Directorate, at the District level both urban and rural for providing us all the support in completing the study through their inputs, suggestions, data etc.

1.5 We would like to express our appreciation to the following who have spared their valuable time to give their suggestions for the study especially the office bearers of KGMOA.

- Members, Task Force on Health - Dr. Ramesh Bilimagga Dr. Maiya
- Dr. Latha Jagannathan, Dr. Thelma Narayan & Others
- Prinicpal Secretary (Health) - Mr.Abhijit Sengupta, IAS
- Commissioner of Health – Mr. Sanjay Kaul, IAS
- Project Director, IPP-IX – Mr. G.V.K.Rau, IAS
- Deputy Secretary – Mr. Mohan Chakravarthy, KAS
- Director of Medical Education - Dr. Seethalaxmi
- Project Administrator, IPP-VIII – Dr. Jayachandra Rao
- Directorate Staff- Additional Directors, Joint Directors, Deputy Directors, Chief Administration Officer, Administration Officer & Others.
- Divisional Joint Directors – Bangalore, Mysore & Gulbarga
- Office bearers - Karnataka Government Medical Officers Association
- Staff of IPP-VIII, IPP-IX, KHSDP & AIDS Society

- District Health Officers & District Surgeons of Gulbarga, Mysore, Kolar, Belgaum, Bangalore – Urban & Rural Districts
- Medical Superintendent & Staff – Jayanagar General Hospital
- Director & Staff – State Institute of Health & Family Welfare
- CEO – Zilla Panchayat - Mysore – Mr. Sundar Naik, IAS
- Medical Superintendent & staff - K R Hospital, Mysore
- Deputy Director, Indian System of Medicine & Health, Bangalore.
- Dr. David Peters - Public Health Specialist, World Bank, India Office, Delhi
- Staff at Office of Task Force especially Dr. Deepak & Lakshmi
- Administrative Medical Officers and Staff at PHCs/CHCs/Taluk Hospitals and District Hospitals in Gulbarga and Bangalore Rural Districts.

2. EXECUTIVE SUMMARY

2.1 This study is instituted by The Task Force on Health, Government of Karnataka, to study if any anomalies in the organization structure and present reporting system in the hierarchy of the Dept. of Health & Family Welfare Exist and the possible ways of addressing them and improve system to face the challenges posed by the external environment of the day to deliver quality health services with equity.

2.2 M/S. A.F. Ferguson & Co. (AFF) has been assigned the task to study the above mentioned tasks and also the possible work areas or the essential job descriptions of the unique positions in the organization. This part of the report forms the Volume I (Review of Organization Structure) of the report.

2.3 The methodology has been a qualitative approach of data collection and discussions with various people involved in the system. The key issues addressed in the process of study are:

- Increase focus on Promotive and Preventive Health (Public Health)
- Equal promotional avenues for Clinical staff
- Increase the morale of the people working in the system
- Increase the accountability of the personnel on the performance of the system
- Bring all round development in the state in the area of Health care to remove regional disparities
- Identify the key training areas required for keeping the technical personnel abreast with contemporary knowledge and thus contribute for the success of the department

2.4 The key issues observed during the study are :

- Very wide span of control for DHS / commissioner, to the extent of handling the national and state health programs directly
- More importance to the stream of Public Health personnel during certain period, thus providing more promotional avenues for personnel with DPH qualification
- Improper division of functions to Public Health specialization people and the clinical people has lead to skewed promotional avenues.

- Subsequently, after having brought both Public Health (both preventive & promotive) and Medical (curative / clinical) into the same stream, the importance for public health has diminished.

- The reliance on clinical personnel on carrying out the public health programs leading to dilution of both clinical and public health activities

- Improper coordination among the main Health & FW department and the Externally Aided Projects (EAPs), leading to duplication of certain activities.

- Dual reporting at which the administrative reporting has taken more importance

- Reporting to peer groups for lack of promotional posts at certain levels in the hierarchy leading to lack of authority in such posts.

- Neglected North Karnataka region

- Redundant DJD position

- Lack of Health directed leadership from ZP

- Imperative need for clearly defined job roles at all levels

- Poor health management and programme management skills among senior health staff at all levels

- Multiple training programmes leading to duplicity without clear objectives and outcomes

All the above issues are looked at primarily from the structure point of view and are addressed accordingly. The key recommendations are given as below:

- Bifurcate the Directorate of Health Services of the Department of Health & Family Welfare into two basic functions of Clinical & Curative health (Medical) and Preventive & Promotive health (Public Health) and merge all the activities accordingly to these functions.

- Have a common entry point at PHC level for all cadres and divide into Medical and Public Health from Taluka level hospital onwards or from the Primary Health Centre itself as suggested by Jungalwalla Committee report in mid seventies

- Personnel to be sent to specialisation courses depending on the requirement of the department

- Have lateral entry for the specialist cadre if found imminent. However, the option of hiring external doctors on contractual basis can also be considered.

- Enhance the capabilities of the planning wing to work on the issues of short-term and long-term avenues / strategies for the organization

- All the future External aided Projects under the control of Commissioner/DGHS, with a Director as head of EAP and thus converting the projects into programmes mode to be executed by the relevant functionaries in the department itself

- Emphasis for the NGO participation in the activities of the health Dept. esp. related to Promotion and Preventive Health. To have a Nodal Officer/ Consultant on Advisor in the NGO Partnership Cell in DHS who will coordinate all the enquiry's, execution and monitoring of NGO activities through a single window at the DHS.

- A separate cell for all procurement, maintenance and construction activities as part of the Directorate of Health which follows the World Bank Aided KHSDP norms

- Create an autonomous institute in form of State Institute of health & Family Welfare (SIHFW) and provide all inputs to manage it independently.

- To create mechanisms to improve capacity building by induction training, retraining in clinical skills at periodic intervals, management training for all Administrative posts, create incentive mechanisms, increase pay scales, motivational programs at regular intervals, reward outstanding workers and provide proper infrastructure both at the health institution and official residence.

3. INTRODUCTION

3.1 A.F.Ferguson & Co. – MCS division (AFF) have been retained by Karnataka Health Systems Development Project (KHSDP) to review the structure and functions of the Health & Family Welfare Department and to design of job responsibilities for offices/posts in the said Department.

Background to the Study

3.2 Karnataka State has had an impressive record of development and has indeed been a pioneer in public health development. The present basic structure which has evolved from the system in vogue in the Princely state of Mysore, has been remarkable for its approach to primary health care.

3.3 The planned focus of the health department has eroded over the years leading to the following key concerns of the department as mentioned by the Task Force on Health:

- Neglect of public health
- Distortion in Primary Health care implementation
- Poor Governance
- Human Resources Development Inadequately addressed
- Lack of integration of Externally Aided projects with the mainstream

3.4 A need was felt to bring about higher emphasis in public health care and resolve the key issues outlined for effective implementation of National Health programmes. Health care and public health thus being one of the thrust areas for development and improvement, the Government of Karnataka has considered the need for review of the current state of Health System so as to ensure 'Health for all' with equity and quality.

3.5 In order to propose measures to improve the public health care systems in the State of Karnataka, the Department of Health Services and Family Welfare (DHS) has set up a Task Force, consisting of eminent persons in various fields, which will examine the issues involved and propose measures which could be adopted by the Government.

3.6 In this regard, the Task Force has conducted a preliminary study and presented an interim report dealing mainly with short-term recommendations, which can be implemented within a period of 6 months. It has also identified areas of concern, which can be accomplished in the medium and long term. The Task Force invited AFF for consultation in review of structure and functions and design of job responsibilities for offices/posts in the Health & Family Welfare Department.

Terms of Reference

3.7 The Terms of Reference (ToR) for the study is as follows :

- To collate the available job descriptions and related information from various offices visited and submit the same to the task force

- To review the present structure and functions of offices in the Health & Family Welfare Department
- To determine improvements/changes and to design job responsibilities for various posts of Health & Family Welfare Services

Scope of Work

3.8 The scope of work for the study covered :

- Collation of Information
  - Collection & submission of existing job descriptions and related information from the various offices visited. These will subsequently be collated and submitted to the Task Force.
- Review of Structure
  - Understanding existing organisation structure and reporting relationships of the directorate
  - Reviewing the authority-financial and administrative powers for the various posts and suggesting changes to facilitate transaction processing.
  - Review of existing cadres and identification of new cadres/levels such as vigilance cell, selection posts etc and redundant positions
  - Re-organisation of staffing pattern to facilitate equitable distribution of work in line with seniority, span of control, job responsibilities.
  - Redefining Job Roles wherever applicable
  - Determining the need for review of procedures
- Defining Job Responsibilities
  - Identifying the key qualifications and experience required for various posts defined in the structure recommended
  - Determining the key result areas of these posts
  - Defining the job roles and activities to be performed by the personnel manning the post
  - Determining the training requirements in line with the job roles envisaged, the requisite qualifications for training, whether they should be cadre options (clinical/public health) etc.
  - Identification of working hours, stay in quarters and volume of work (if applicable)

Approach & Methdology

3.9 The study commenced in first week of October, 2000 and the AFF's team visited the Directorate of Health Services (DHS) and had discussions with the Commissioner,

Director, various Additional Directors (ADs), Divisional Joint Director, District Health Officers, District Surgeons Joint Directors (JDs), covering their responsibilities, reporting relationships, operational constraints etc. In addition we met various officers of the Primary Health Centre (PHC), Community Health Centre (CHC), Sub-Centres, Taluk Hospital, District hospitals for both rural and urban areas. Table 1.1 provides list of officers/offices visited.

Table 1.1

Area / Category	Bangalore Rural	Gulbarga Rural
Sub-Centre	Shanmangla	Kadacharala
PHC	Bidadi	Malkhed
CHC	Magadi	Mudhol
Taluk Hosp	Ramanagara / Channapatna	Sedam
District Hosp	Mysore (ED Hospital) General Hospital, Jayanagar, Bangalore	Gulbarga, Raichur
DHO	Bangalore Rural	Gulbarga, Mysore,Raichur
Teaching Hospital	KRHospital, Mysore	

3.10 The study involved detailed discussions with the above members and the Task Force members covering various aspects of the study. Focused group discussions were held with the Task Force and DHS and also representatives of KGMO for confirmation of observations. Our observations and recommendations are provided in two volumes covering :

- Volume I : Review of Organization Structure
- Volume II : Detailed Job Responsibilities

3.11 This report (Volume I) covers the following :

- Section 3 : Introduction
- Section 4 : Review of Organisation Structure and Job roles
- Section 5 : Proposed Organisation Structure
- Section 6 : Review of Cadre rules
- Section 7 : Re-alignment of staffing patterns
- Section 8 : Observations on Need for Procedure Review
- Section 9 : Recommendations and Conclusion

4. REVIEW OF ORGANISATION STRUCTURE AND JOB ROLES

4.1 This chapter covers briefly the existing and proposed activities of the Department of Health, Government of Karnataka (GoK) followed by a review of the organisation structure and job roles of key functions. This chapter will conclude with the recommended top organisation structure for the DHS, GoK and its salient features.

4.2 The Department of Health is responsible for providing health care services in Karnataka. The major programmes undertaken and services provided by the department are:

- Primary Health Care
- RCH programmes (family welfare and related programmes)
- Various National programmes for prevention and control of Vector Borne diseases such as Malaria, Filaria etc, Leprosy, Tuberculosis (TB) and Blindness
- Prevention and control of communicable and diarrheas diseases
- Clinical services (Curative Services)
- Immunization programmes – Universal programs of Immunization
- Nutrition programmes – Nutrition education and demonstration
- Health education and training programmes
- School health programmes and educational and environmental sanitation
- Laboratory services

4.3 The above health services are provided through a network of

• Sub – Centres	:	8143
• Primary health centres (PHCs)	:	1670
• Primary Health Units	:	583
• Community Health Centres (CHCs)	:	249
• Taluk, Teaching, Specialised, General/Maternity and District Hospitals	:	177

* *Source Annual report of Department of Health & Family Welfare, 1999-2000*

4.4 The above institutions are determined by the facilities provided in terms of number of beds.

4.5 With the objective of direct involvement of people in health care, the 'Panchayat Raj', introduced in Karnataka in 1983, a number of schemes were transferred from the state level to the district level under the Zilla Parishad(ZP), effective from April 18, 1987. Thus the responsibility of management of Taluk Hospitals downwards is under the ZP.

4.6 The Department of Health and family welfare is headed by the Principal Secretary (PS) – Health who reports to the Minister of Health and Family Welfare. The PS – Health covers the following areas :

- Autonomous Institutes
- Indian Systems of Medicine
- Directorate of Health and Family Welfare Services(DHFWS)
- Drug controller
- Externally Aided Projects
- Deputy Secretaries (Secretariat)

4.7 The present top structure of the Department of Health and Family Welfare is provided in Exhibit 4.5

4.8 The DHFW activities and the organisation structure review is presented under the following categorization:

- Externally Aided Projects (EAP)
- Indian Systems of Medicine
- Directorate of Health and Family Welfare Services (DHFWS)
- Divisional Level
- District Level

Externally Aided Projects (EAP)

4.9 The Department of Health has created independent, separate cells for the externally aided projects with each Project Director reporting to the Principal Secretary - Health. The ongoing EAPs under the Department of Health (DHFW) are :

- **IPP IX** – This is being implemented in the state of Karnataka since 1994 with the assistance from Government of India and World Bank. The specific objective of the project is to implement a programme sustainable at village level to reduce crude birth rate, infant mortality rate and maternal mortality rate and increase couple

protection rate to reach the national targets. IPP-IX carries out following functions for achieving the set objectives of the project.

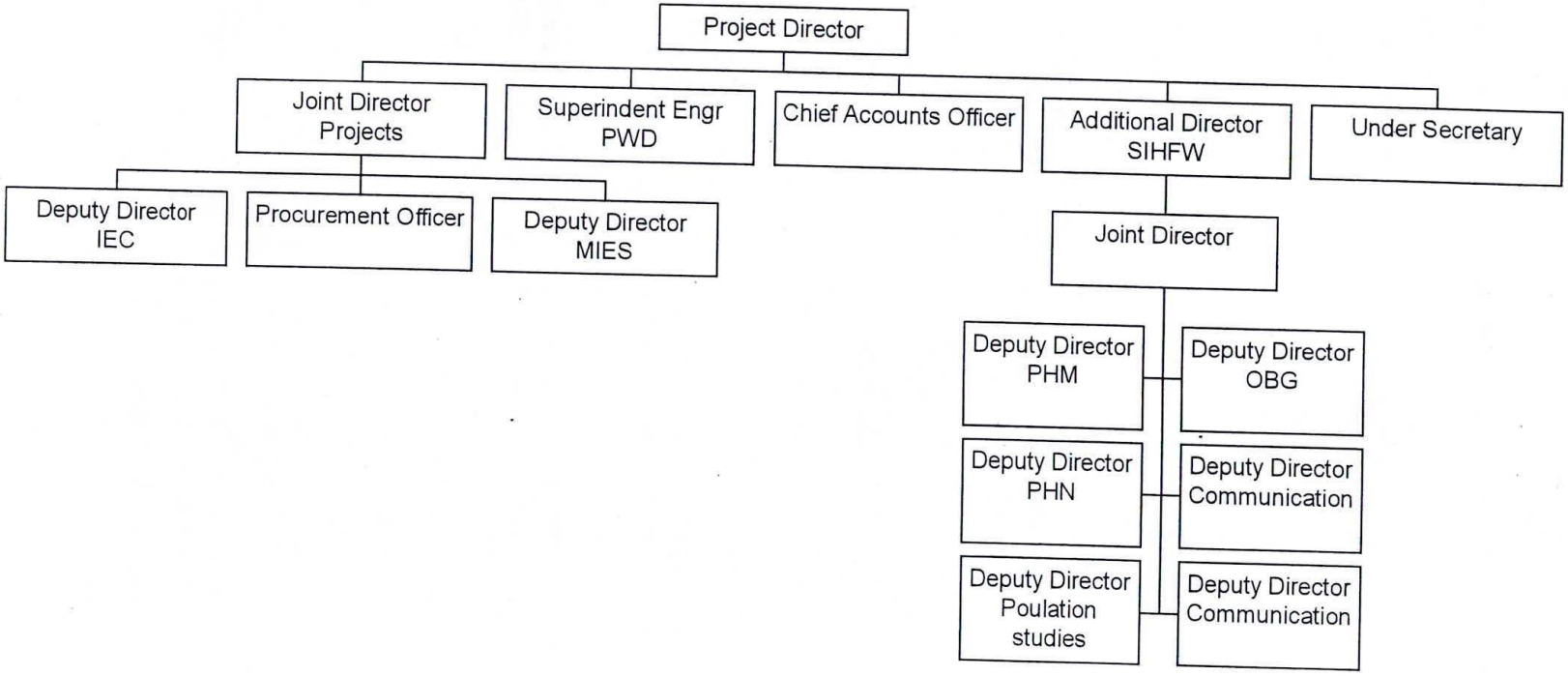
- To involve the community in promoting and delivery of family welfare services.
- To strengthen the delivery of services by providing
  - Equipment kit and supplies to TBAs, subcentres and PHCs
  - Make ANMs at subcentre mobile by providing loans for purchase of two wheelers.
  - Building of subcentres with provision of residential accommodation for ANMs
  - Building for Primary Health Centres
  - Residential quarters for Medical Officers.
- Improve the quality of services by providing training to personnel, official and non-official at various levels including TBAs, Community leaders and voluntary agencies.
- Strengthen monitoring and evaluation by developing and installing MIES from District to State level.
- The IPP-IX has implemented Civil components in 17 districts of the state and IEC and Training components in all the districts.

The organization structure of IPP IX is showed in exhibit 4.1

- **IPP VIII -** This was launched during 1994-95 to cover the Bangalore Metropolitan Area with financial aid from the World Bank under Family Welfare (Urban Slums) Project. The main objectives of this project are:
  - Deliver family welfare, maternal and child healthcare services to the urban poor and to promote safe motherhood and child survival
  - Reduce fertility rate among eligible couples, promote consciousness against early marriage of the daughters
  - Promote male participation in family planning with a view to reduce the burden on women
  - Create awareness of personal hygiene and to maintain a better environment for prevention of diseases
  - Non-formal education and vocational training for women to help them in self-employment
  - Promote female education

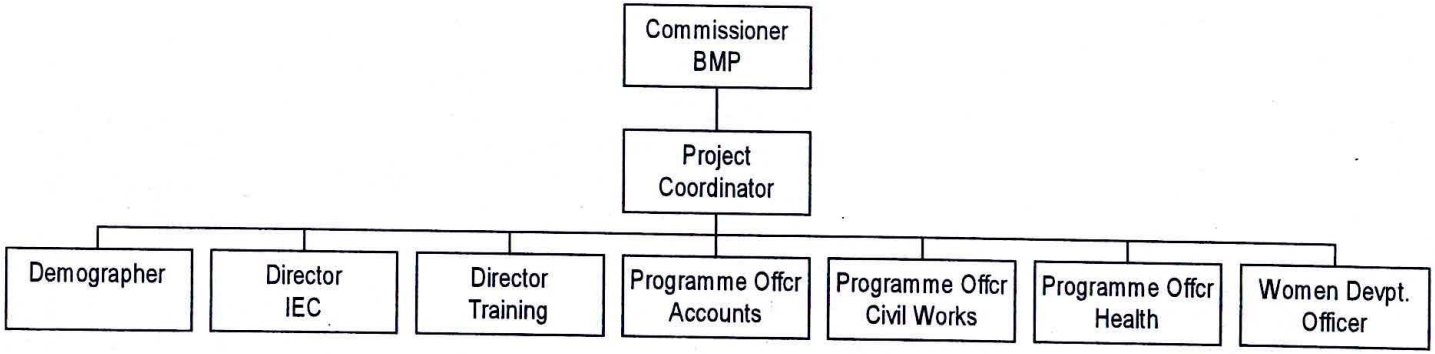
Organization Structure - IPP - IX

Exhibit 4.1



Organization Structure - IPP VIII

Exhibit 4.2



This project completes its life period by June, 2001 and all of its present activities were planned to be shifted to the Bangalore Mahanagar Palike which manages the hygienic conditions in the slums in the capital.

The organization structure of IPP VIII is showed in exhibit 4.2

- **AIDS Society of Karnataka** - This is a 100% centre sponsored scheme under the guidelines of national AIDS Control Organization, Ministry of Health and Family Welfare, Government of India, as the national AIDS Control Programme in Karnataka. The Present Phase – II of the AIDS Control Project is officially launched during December – 1999, for a period of five yeas (from 1999 to 2004). The objectives of Phase – II of AIDS Control Project are:
  - Reduce the spread of HIV infection in Karnataka State
  - Strengthen Karnataka State's capacity to respond to HIV/AIDS on long term basis.

  This project has many officers deputed from the Department of Health & Family Welfare and a hand-in-hand working is required among all the relevant functionaries for effectively combating the AIDS. The organization structure of Karnataka AIDS society is showed in exhibit 4.3

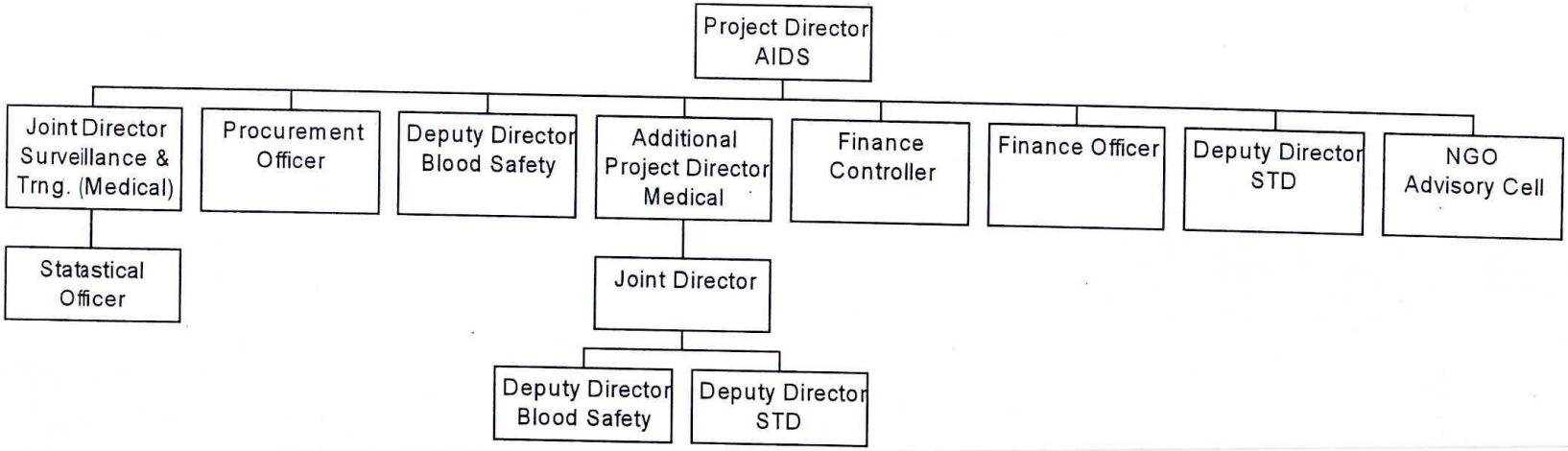
- **Karnataka Health Systems Development Project (KHSDP):** The Karnataka Health Systems Development Project (KHSDP) is a World Bank aided project setup in 1996 with a project base of Rs. 546 Crores spread over a period of 6 years to improve the secondary level of health care in Karnataka. KHSDP has been setup with the following objectives:
  - Improvement in the performance and quality of health care services at the district and sub-district and sub-district level of the health care system
  - Narrowing the current coverage gaps by facilitating access to health care delivery, and
  - Achievement of better efficiency in the allocation and use of health resources

The project components and sub-components are :

- Management Development and Institutional Strengthening:
  - Improving the institutional framework for policy Development
  - Strengthening management and implementation capacity; and
  - Developing surveillance capacity for major communicable diseases.
- Improving Service Quality, Access and Effectiveness
  - Extending/ renovating Community, Taluka and District hospitals
  - Upgrading their clinical effectiveness

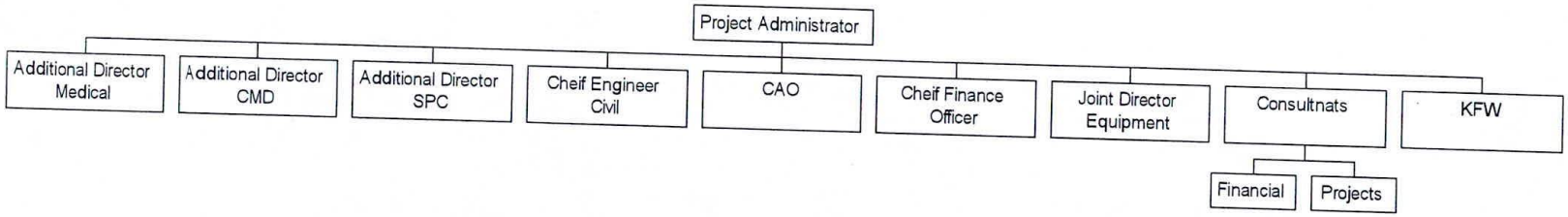
Karnataka AIDS Prevention Society

Exhibit 4.3



Organization Structure - KHSDP

Exhibit 4.4



- Improving referral mechanism and linkage with primary and tertiary level; and
- Improving access and equity to disadvantaged sections

The following functions are being carried out for achieving the objectives of the project:

- Civil Works: The project is working for renovation and expansion of 74 Community Hospitals, 104 Sub- Divisional Hospitals and 21 District Hospitals
- Procurement: The project undertaking procurement of Medical and other equipment, Vehicles and Medicines.
- Training: Project is also working towards the training of doctors in different specialties, Pharmacists, Technicians and Nurses.

The organization structure of KHSDP is showed in exhibit 4.4

The Reproductive & Child Health Programme (RCH) funded by World Bank is being carried out by the Department itself and so also the Blindness Control programmes funded by Danida.

Indian Systems of Medicine and Homeopathy (ISMH)

4.10 ISMH is rendering medical relief to the public in Ayurveda, Unani, Naturopathy, Siddha and Homeopathy systems of Medicine and regulates Medical Education, Drugs manufacture and practice of medicine in these systems.

4.11 The Director of ISMH is independent of Directorate of Health Services. The current study being focused on the working and reorganization of Directorate of Health Services, the details of the ISMH are not covered in this report.

Directorate of Health and Family Welfare Services (DHFWS)

4.12 The key activities performed at the Directorate summarized below are :

- ***Planning :***
  - Scrutiny of planned proposals at pre-budget stage before submission to Secretariate
- ***Budgeting*** :
  - Scrutiny of budget proposals and release of budget to all schemes/institutions under DHS
- ***Accounting and Finance*** :

- Consolidation of statement of Expenditure received from various institutions
- Reconciliation with Accountant General's records
- Countersignature of DC and NDC bills drawn by Government Medical Stores (GMS) and Public health institutions

- ***Payroll and Personnel***
- ***Programme Monitoring and Implementation***:
  - Monitoring of National and state level health programs
  - Assessing community needs regularly and ensuring their addressal through different hospitals.
  - Curative preventive and promotive health programmes through its network of PHC's, CHC's, Taluk, subdivision & District hospitals
  - ***Purchases and Stocks*** :
  - Procurement of all drugs and equipment (except that for TB, Malaria and Leprosy) by GMS
  - Requisition and obtain drugs for TB, Malaria and Leprosy from Government of India
  - Participating in finalisation of rate contracts
  - Supply and distribution of drugs, instruments and surgical equipment to institutions under its control and contraceptives and Family Welfare drugs throughout the state.

4.13 The DHFW is headed by the Commissioner who reports to the Principal Secretary (Health). The present top organization structure of DHFW is given in Exhibit 4.5

4.14 The post of Commissioner, Department of Health & Family Welfare Services (held by an IAS officer) was created during 1997-98 for effective delivery of health services both preventive and curative to the people of the state. All the functions related to DHS apart from the ones managed by different projects are routed through Commissioner.

Divisional Level

4.15 The health care service delivery network for the state of Karnataka is grouped under four divisions namely,

- Bangalore
- Mysore
- Belgaum
- Gulbarga

4.16 The Divisional Joint Director (DJD) is the officer in-charge for Health and Family Welfare Services for each of the above divisions. The key activities of the DJD are :

- Technical guidance to district level authorities in implementation of Health and Family Welfare programmes
- Monitor the performance of hospitals of more than 100 beds, which are not being managed by any District Surgeon or not a teaching hospital
- Inspection of various schemes in Health and Family Welfare sectors being implemented by the district authorities
- Countersignature of DC Bills and NDC bills of district hospitals and other specialised hospitals

4.17 The organisation structure at the divisional level is given in Exhibit 4.6

District Level

4.18 The District Health and Family Welfare Officer (DHO) is the head of the department at the district level and functions at the Zilla Parishad as posted by the State Government. He is responsible for the implementation of the health programs of the district both to the Zilla Parishad and the Directorate.

4.19 The key activities at the District level are :

- Implementation of national programmes at the primary and secondary level of healthcare delivery system
- Health education to the public on the various health programmes conducted by the DHFW
- Planning and implementation of various health programmes (preventive and promotive) through community needs assessment approach and also based on guidelines issued by Government of India and State Department of Health & Family Welfare
- Provision of curative services at the various health centres and hospitals under the DHFW

The present organisation structure at the district level is provided in Exhibit 4.7

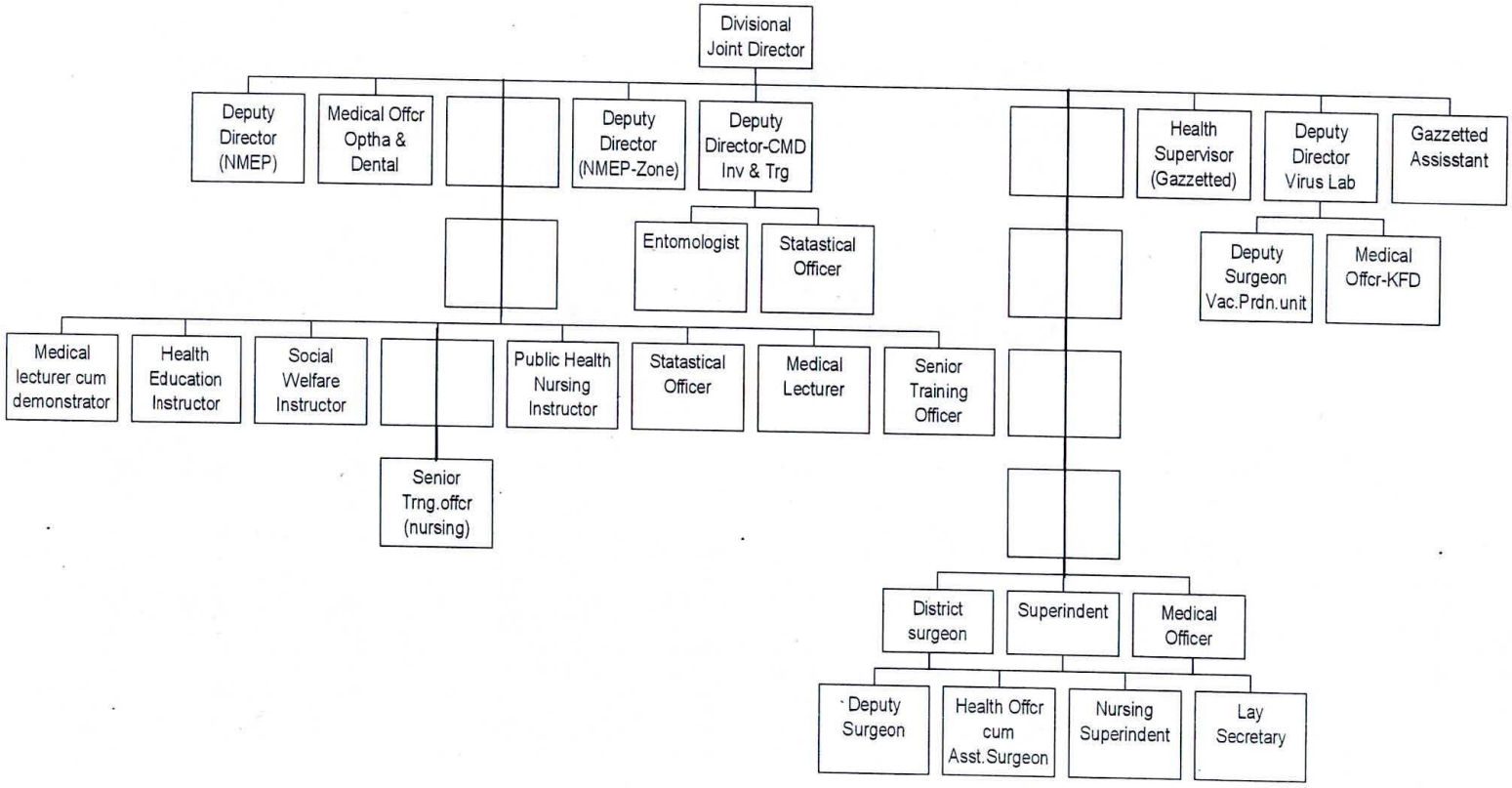
The present staff structure from the village level onwards is shown below :

Village : VHF - Anganwadi - Dai
Sub Centre : JHA (F) / (M) , Dai / Ayah
PHC : MO / LMO, Staff Nurse, Pharmacist, Lab.Tech, SHA (F / M), FDC, D Group
CHC : Physician, Surgeon, OBG, Paed, Anaesthetist,Dentist (Specialists) , GDMO, Staff Nurses, Pharmacist

Organization structure at Divisional level (Gulbarga) - current

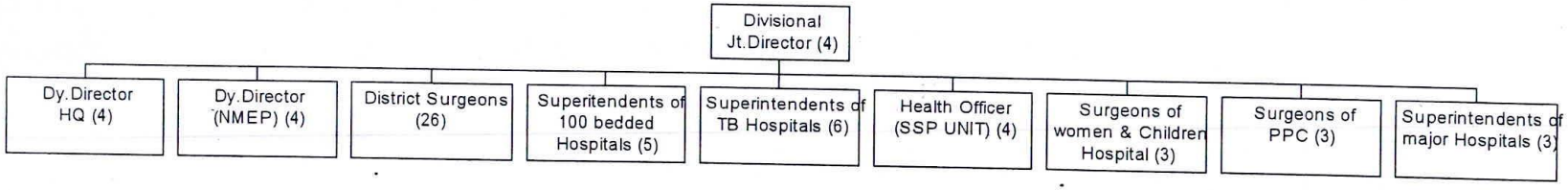
Exhibit 4.6

This structure is not uniform in all divisions



Divisional DHFW - Current

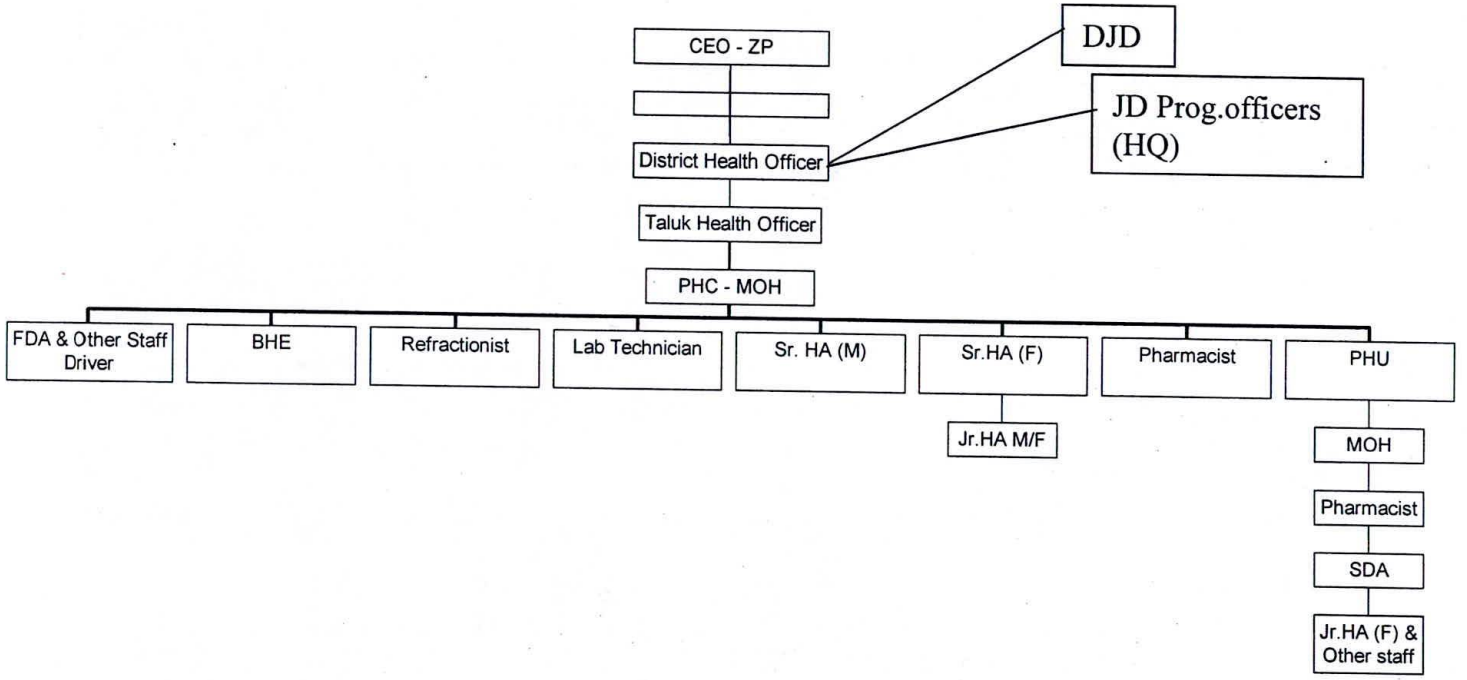
Exhibit 4.7



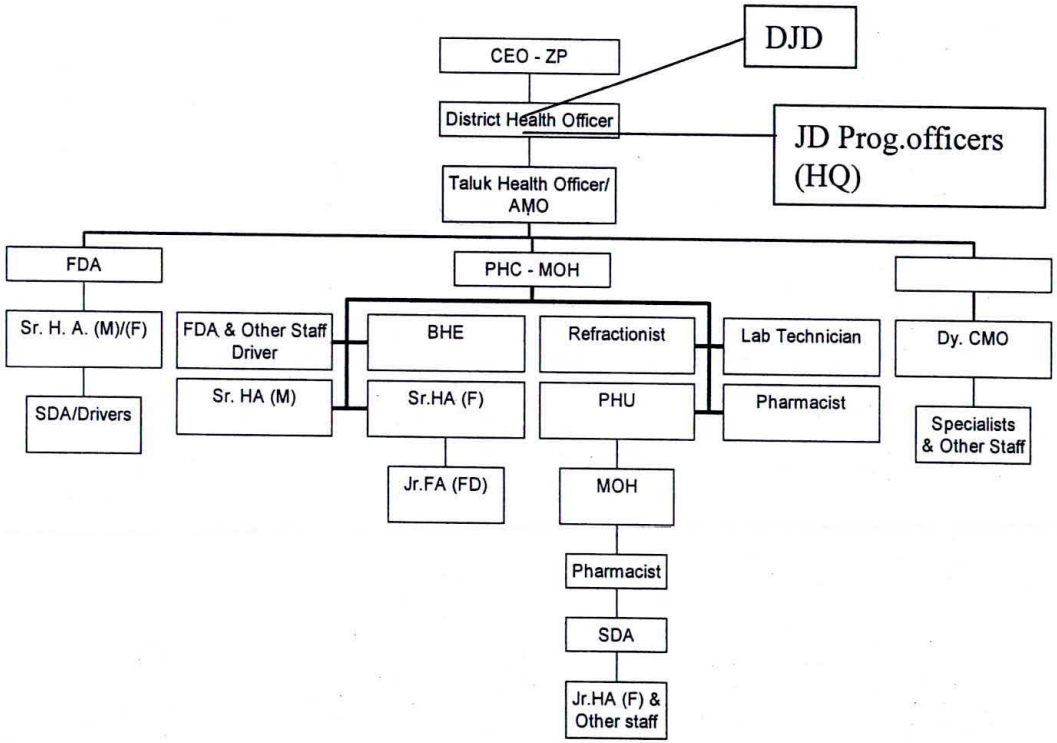
Primary Health Centre
Organisation Structure - Current

Exhibit 4.7

Structure varies from PHC to PHC - District wise

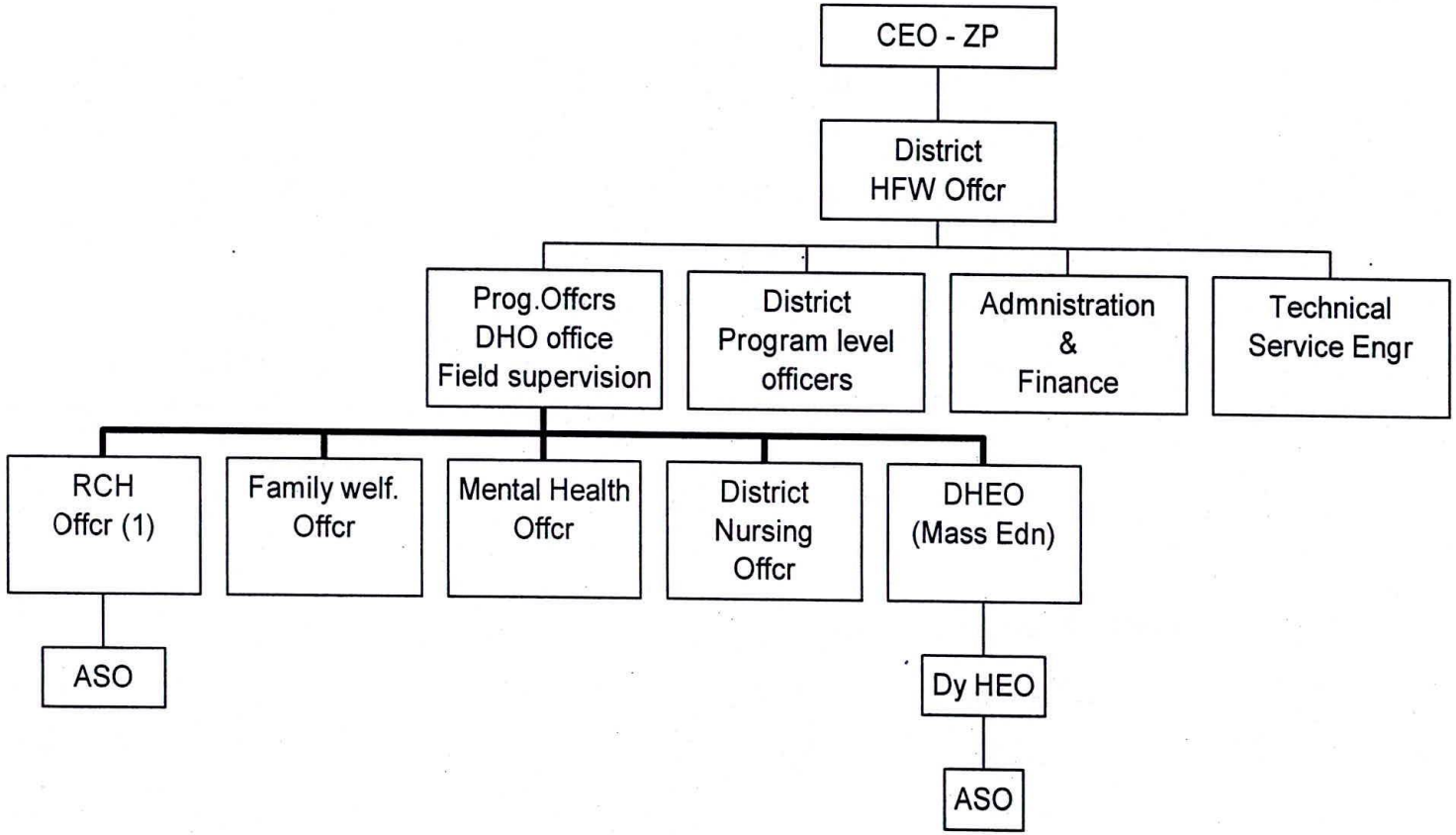


Taluk Health Office
Org. Structure - Current
Exhibit 4.7



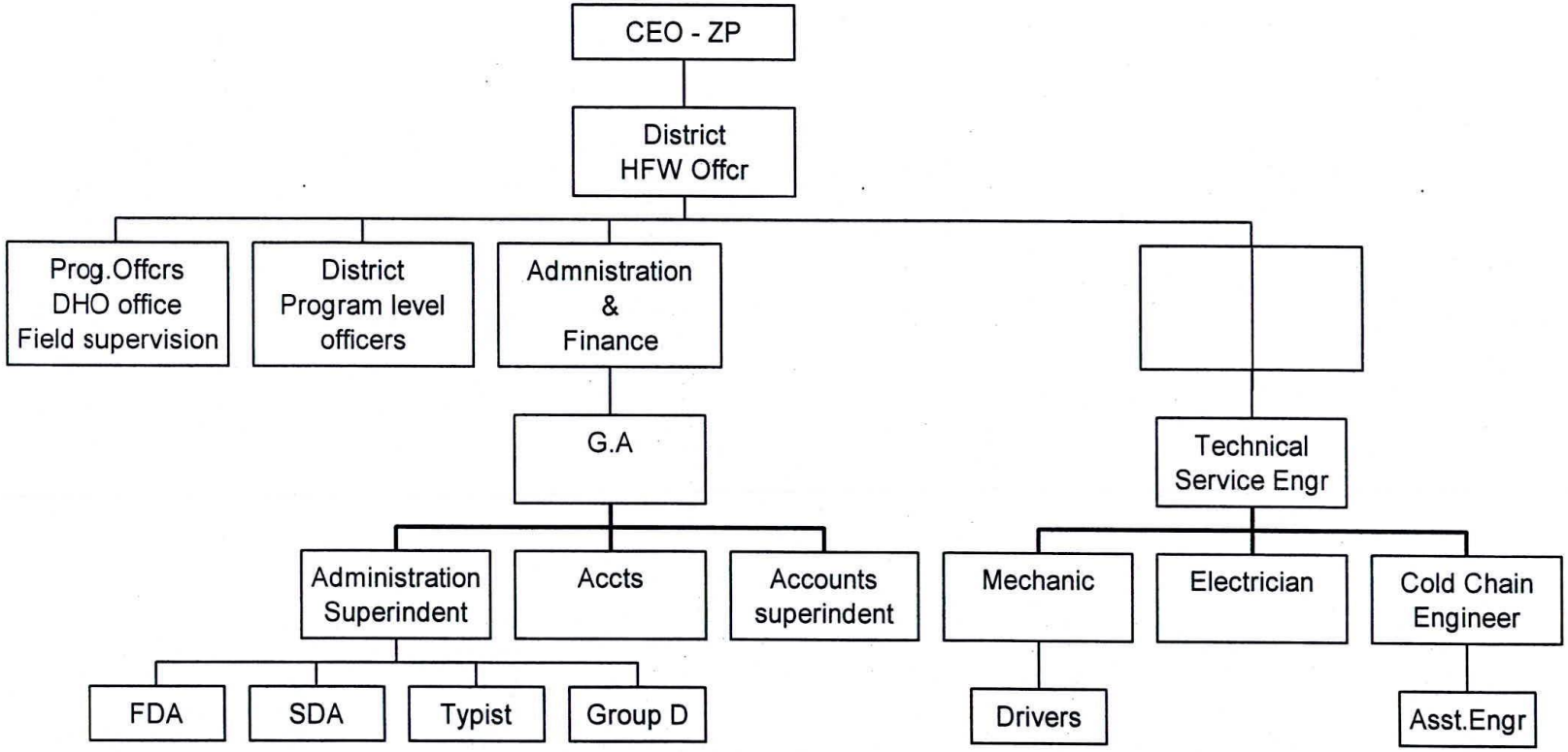
District Health & Family Welfare Office
Administration Control Chart - Current

Exhibit 4.7

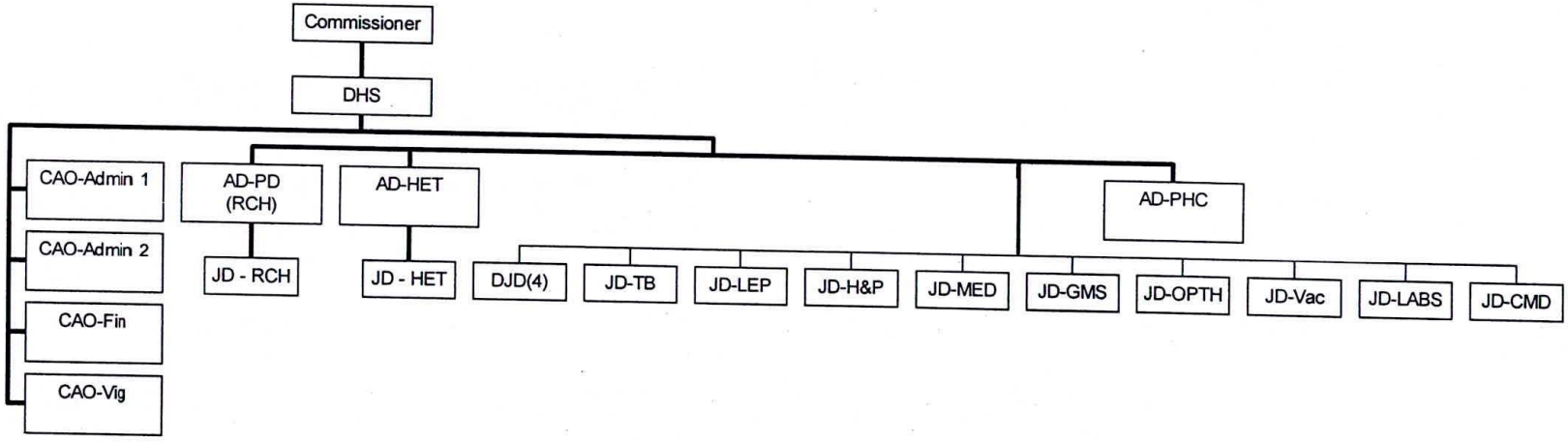


District Health & Family Welfare Office
Administration Control Chart - Current

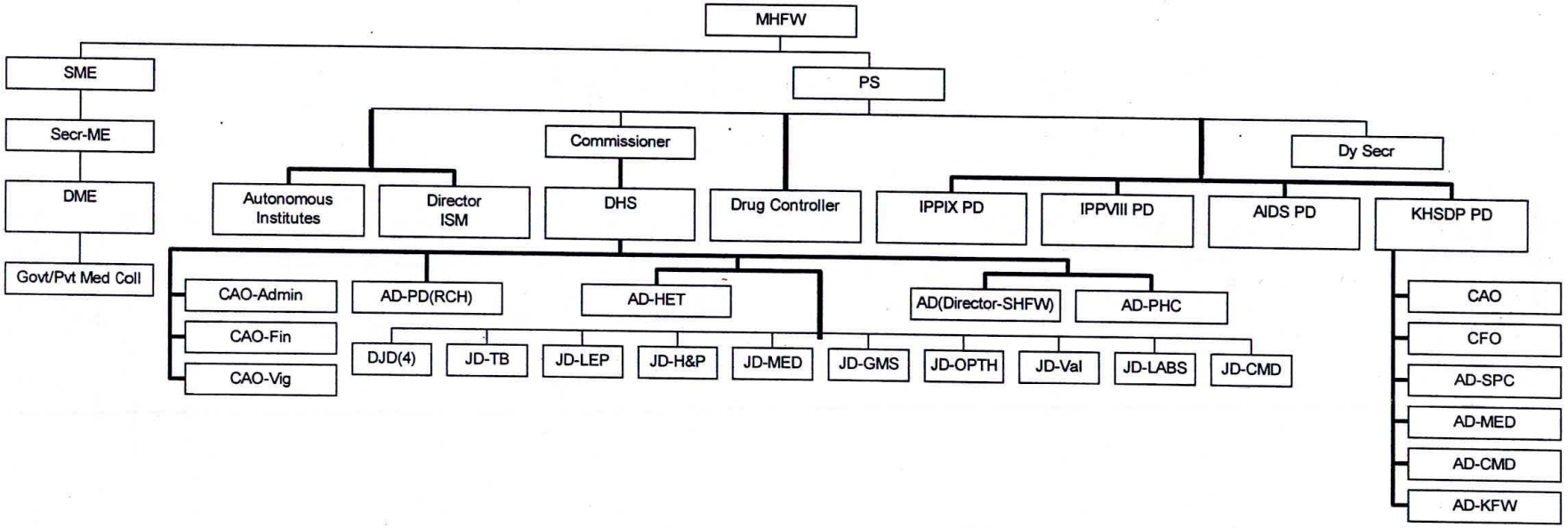
Exhibit 4.7



Department of Health & Family Welfare - Govt of Karnataka
Organization Structure - Current
Exhibit 4.7



Department of Health & Family Welfare - Govt of Karnataka
Organization Structure - Current
Exhibit 4.7



The basic primary healthcare concept consists of one CHC with 3-4 PHC's. The staff of CHC will have the dual role of executing both clinical as well as public health care to the community through the Taluk Health Officer.

Observations in Current Organisation Structure

4.20 The notable observations arrived at after detailed discussions with key personnel of Department of health and members of Task Force and analysis of the organisation structure are given below :

Span of Control

4.21 The DHFW is a complex Health service set-up with key activities of administration, public health care and clinical health care having high differentiation and specialization

4.22 . Such set-ups require limited span of control especially at the top for optimum supervision and functioning. However, the Director of Health and Family Welfare has 18 functional personnel including 3 Additional Directors and 10 Joint Directors directly reporting to him, thereby having a wide span of control.

Curative Vs Preventive

4.23 The role of public health programmes is designed to be primarily focussed on the preventive and promotive aspects wherein a need has been determined for improving the basic health of the society and prevention of illness. However, it has been observed that there is more emphasis on the curative aspects of health vis-à-vis preventive / promotive health by the Department of Health (GoK). As observed most of District Health Officers are clinicians without any training in public health. There is severe mismatch of specialists to their place of posting. Senior specialists are still serving at PHC's.

4.24 Further the public health staff at the Taluk hospitals and District hospitals do not have separate infrastructure for conducting their activities. There is a lot of reliance on the medical wing personnel for implementation of public health programs. This results to overload of activities/responsibilities on the medical wing personnel further leading to dilution of role either on Public health or on clinical due to lack of time. There is also lack of managerial and administrative capabilities of Senior Personnel of the Dept from Taluk level onwards

In-equality in Promotion Opportunities between Public Health & Clinical

4.25 Around 1976, during the emergence of public health in the DHFW, the promotion opportunities for the Public Health qualified personnel rose tremendously with the result of clinical personnel higher on the seniority list positioned way below in the organisation structure. This was mainly due to the mandatory requirement of Public Health

qualification from the post of DHO onwards, i.e. role of DPH qualification as criterion for promotion to DHO/JD/AD/DHS created imbalance. This being rectified in 1992, the growth opportunities became equal for both Public Health and clinical personnel.

4.26 Thus, in the district level the career opportunities are equal for both Public Health personnel as well as Clinical Personnel. However, going by the need of specialisation at the senior levels, the promotional path for a District Surgeon (DS) is limited to 3-4 posts at the JD level as against around 12 JDs posts for the DHO.

Multiple authority for certain functions

4.27 It has been observed that the same function is assigned to more than one JD/AD leading to non-optimum utilization of resources and duplication of efforts. Especially while planning Externally Aided Projects (EAP), number of imbalances occurs in staff positioning, training, etc as the activity is in project mode and constraints in terms of availability of time exist. Certain examples are given below :

- AD (HET) handles health training for the public while training for public as well as personnel of DHFW is also conducted by the RCH cell, IPP, KHSDP and SIHFW.

- Research/Studies are organized by PRC, KHSDP, IPP VIII, and IPP IX

Improper Positioning of Functions

4.28 It has been observed that there is no streamlining of functions in terms of reporting hierarchy and departmental responsibility in the organisation structure of the DHFW. Thus while the planning, funding and review is done by certain section of personnel, another conducts the actual implementation with no reporting relationship defined between both sections. This will result in in-effective implementation of the various programs. Certain examples of the same are given below :

- KHSDP as an EAP, created a position of AD (CMD) who is to cover all public health activities for the state relating to communicable diseases. This AD post reports to the Project Director (KHSDP) and is expected to work with the staff of the Department of Health. In the DHFW structure, there is a JD (CMD) who reports to the DHS and has no reporting defined to the AD (CMD), till recently. Only recently a government order has been issued asking three Joint Directors (CMD, Lab and M& F) to report to AD – CMD. Moreover there seems to a lack of co-ordination between the AD(CMD) and DHS office.

- Similar to the above, there is a AD (Medical) reporting to the Project Director (KHSDP) while the JD Medical reports to the DHS office. Nearly all new posts created in the EAP (project mode of functioning) work in isolation from main DHS, thereby creating duplication and confusion in the roles and responsibilities.

Dual Reporting

4.29 Discussions with a cross-section of personnel of DHFW revealed that there is an overlapping of authority and lack of clarity in responsibility. E.g. the DHO being under the District cadre, reports administratively to the CEO, Zilla Parishad, while functionally he reports to the DJD. Many were of the view that in this context of multiple line of command, the one through which the inputs for Confidential Report are taken is the most responsive one. Thus, the DJD, a department functionary, couldn't contribute to the development of the respective district.

Peer Reporting

4.30 As per cadre policies, in certain cases, the post of administrative head is held by the senior most person in that office. E.g. the senior most Sr. Specialist holds the post of the District Surgeon (DS). As these posts are not promotion posts, the personnel holding these offices find it difficult to effectively discharge their duties due to non-reporting by other peer personnel.

Disparity of Health care development in Northern Karnataka vis-à-vis other regions

4.31 Field visits to the Gulbarga district health centres revealed a very low health care reach and infrastructure for services. It was found that the situation was very grim when compared with national health standards

4.32 The regional disparity between Northern Karnataka and other regions are outlined below:

- High number of vacancies due to non reporting of personnel deployed/posted
- Abysmally low health care awareness amongst the public
- Distance from directorate leading to ineffective governance
- Low Morale amongst staff

Poor health infrastructure including poor maintenance of existing infrastructure (building, Equipment etc.)

Externally Aided Projects

4.33 The externally aided projects function distinctly from the DHS office despite having the same objectives and operating mechanisms. E.g. the KHSDP was initiated to design and implement various health programmes in co-ordination with the DHS office to improve secondary level health care. However, the KHSDP is considered to be a separate entity with minimal/no co-ordination with the DHS office, thereby resulting in similar activities being conducted parallely by the DHFW and under utilization of various funds at the disposal of KHSDP.

4.34 According to the planning of different Externally Aided Projects, majority of EAPs come to a end of their stipulated period of working while creating a number of new additional posts as dictated by the project modalities. This gives a challenge of repositioning of the personnel at appropriate levels/positions in the hierarchy at the end of the project.

Role of Divisional Joint Director

4.35 The DJD is the overall in-charge of the divisions under him and have the functions of technical guidance and inspection of implementation of various national programme schemes. However, it has been observed that the DJD functions mainly as a co-ordinator between the district and the headquarters and performs the functions of collating information from the various offices under him and submitting the same to the DHS. The DJD does not exercise any administrative or functional powers leading to the redundancy of the post in the overall functioning of the DHFW

Sanctity of certain posts

4.36 The original organisation structure has been modified by creation of new posts based on requirements for a specific activity. However, due to lack of clearly defined roles and reporting relationships, lack of proper authorities and non-cooperation from other members in the system, these personnel holding these posts cannot function effectively, leading to their redundancy e.g. Director - Training. In addition, posts such as Officer on Special Duty (OSD) are created from time to time for specific projects/activities.

Lack of integration of functions

4.37 Currently, the various duties of the staff in the lower level of hierarchy, are defined at a program level. E.g. Lab Technician-Malaria, Lab Technician- TB etc. This lack of integration of functions often leads to under-utilisation of personnel as given below :

- Overload on a certain function while under utilisation of the other personnel
- Lab technicians not interested in doing duties assigned to them, due to higher learning opportunities in other functions. E.g. Lab Technician of TB prefer to do malaria related activities

Similarly the ANM's are overloaded and the male health worker underutilized.

Role of ZP in Public Health Care

4.38 ZP being the administrative authority at the district level has a vital role to play in delivery of health care in the district. Various personnel in the DHFWS were of the view that there exists a misuse of financial and administrative powers by the ZP. This has led to a de-motivation in the department. The various forms of abuse of power indicated by the personnel are :

- Use of Public Health Care facilities for other purposes or for personal work
- Use of Force/pressure tactics to achieve their needs. E.g.:
  - In the event vehicles reserved for public health are not provided to ZP for other use, the personnel are threatened with cuts on vehicle allowance.
  - Delay in payment of salaries
- The ZP has powers to post personnel of the 'C' and 'D' category staff at the district level. However, quite often, such personnel have been posted by the ZP against non-sanctioned posts into the health department.
- Procedural delays such as pending electricity bills, delay in maintenance of equipment and buildings etc.

4.39 Further to the above, the personnel of the DHFWS feel that health programmes are not a priority for the ZP as the ZP personnel do not appreciate the criticality of successful implementation of proposed national/state health programmes. The ZP regularly insists on the DHO and other staff of the DHFWS to be present for all meetings being conducted by them, irrespective of the connection of these meetings to health. These meetings are often of the nature of absenteeism, administration etc., This results in lack of time for personnel of DHFWS to conduct their basic duties of health care thereby providing scope for productivity reduction.

4.40 There is a lack of morale amongst the personnel of DHFWS at the district level due to the authoritative attitude of ZP and the misuse of power. It has been brought to our notice that very often the interference of ZP in the day-day functioning of the DHO and their support to the lower cadres of personnel, result in ineffective use of such staff by the DHO for implementation of health related programs.

Need for Re-defining of Job Roles

4.41 Discussions with various personnel in the DHFWS have brought out a need for clear definition of Job roles at each level. Certain lacunae identified in the current system are :

- The role demarcation of Strategic Planning Cell (SPC) vis-à-vis JD (H&P) in DHS needs to be clearly reviewed in depth and outlined
- The present SPC at KHSDP has not been able to deliver the objectives for which it was set up through KHSDP
- Lack of program orientation in officers
- Specialists of District Hospitals attached with medical colleges are given minimal / no responsibility or authority such as :
  - No additional units/beds provided for their clinical work
  - Only MLC cases and casualty are given to specialists

- Despite senior DHFW doctors in premises, casualty is referred to the Orthopedic units , PG and Junior residents

- Senior personnel are not involved in strategy and planning. E.g. :
  - DHO/DS not involved in technical micro planning of District Health programs or hospitals, current role being administration driven
  - Role of senior personnel currently reduced to transfer of correspondence or provision of data
  - No analysis of information conducted even at certain JD levels on data collated

Specific demerits of the structure

4.42 Key demerits observed in the existing structure are summarized below:

- Very wide span of control for DHS / commissioner, to the extent of handling the national and state health programs directly
- More importance to the stream of Public Health personnel during certain period, thus providing more promotional avenues for personnel with DPH qualification
- Improper division of functions to Public Health specialisation people and the clinical people has lead to skewed promotional avenues.
- Subsequently, after having brought both Public Health (both preventive & promotive) and Medical (curative / clinical) into the same stream, the importance for public health has taken a back seat.
- The reliance on clinical personnel on carrying out the public health programs leading to dilution of both clinical and public health activities
- Improper coordination among the main department and the EAPs, leading to duplication of certain activities.
- Dual reporting at which the administrative reporting has taken more importance
- Reporting to peer groups for lack of promotional posts at certain levels in the hierarchy leading to lack of authority in such posts.
- Neglected North Karnataka region
- Redundant DJD position
- Lack of Health directed leadership from ZP
- Imperative need for clearly defined job roles at all levels

5. Recommendations on Organisation Structure

Principles Behind Proposed Organisation Structure

5.1 The proposed organisation structure has been designed in line with the following principles :

- Equal emphasis for both Public Health as well as Clinical from the District level onwards
- Optimum utilization of all resources across the DHFW
- High priority on Rural health development
- Health MIS and Planning is significant for the functioning of the department
- Role clarity and well defined Job Responsibilities/Key Result Areas
- A Bureaucratic structure
- A Professional Domination
- Accountability to public
- Equity of treatment

VISION STATEMENT

QUALITY HEALTH CARE DELIVERY SYSTEM WITH EQUITY

The Department of Health and Family Welfare is committed to act as a catalyst for progress that will result in healthier people in a healthful environment.

The department will incorporate strategic management to implement a core set of values that are integral to public health. We will translate science and technology into action to safeguard the public's health. We will apply innovative, sound, and reasonable solutions to traditional public health challenges and emerging issues. At the same time, we will retain that, which is good with public health in the state. We will expand knowledge through epidemiology and applied research on health and environmental issues.

The department recognizes its tie with other health and human service agencies to respond to global, national, state, and local public health concerns. We will forge alliances with public and private sectors to ensure that timely, cost-effective, public health interventions are planned and implemented. We will strengthen our commitment to collaborate with other departments.

Our employees are out most valuable resources. We will provide an environment in which our employees strive for excellence, display initiative, and demonstrate achievement. Our employees will continue to promote health; work to prevent diseases, disability, and premature death; and help to assure access to health care for all populations.

This vision of the future is one in which the Department of Health & Family Welfare, communities, local health agencies, Special Institutions, and the private sector across the state cooperate to develop plans, programs, and resources. It guides our work to increase the span of healthy life, to reduce health disparities among different populations, and to assure access to preventive services for all.

MISSION STATEMENT

The Department of Health & Family Welfare is dedicated to promoting health and wellness among people in Karnataka through planning, prevention, service, and education. DH&FW serves to help people attain the highest level of health possible. The DH&FW is a proactive leader and collaborator in assessment, policy development, and assurance, based on science, innovation, and efficiency.

DH&FW affirms that health includes physical, mental, and social well-being, and is dependent on economic and environmental factors, access to health care, and individual responsibility and choice. Although the DH&FW primarily serves people within Karnataka's geographic boundaries, we recognize our interdependence with the larger world.

To achieve our mission, the DH&FW supports :

- Training and technical assistance
- Disease prevention and health education programs
- Epidemiology for surveillance and analysis of health data for intervention and program evaluation
- Development of policies and regulations to optimize health
- Planning and evaluation
- Staff recruitment and development to accomplish our mission, and
- Collaboration with the public, local health departments, other governmental agencies, the scientific community, and special populations.

The DH&FW is dedicated to quality service, innovation, respect for every individual, affirmative action, personal integrity, trust, and high ethical standards.

Quality care for all

5.2 Good health is necessary to the well being of every individual and the society is dedicated, therefore, to providing care for all ages, regardless of race or creed and regardless of their circumstances and ability to pay.

Equity in health

5.3 An atmosphere of equity in health is the stone to progress in the state with all members of society availing healthcare.

Treatment of the whole person

5.4 The patient is entitled to more than physical care, his worth as an individual and his spiritual well being are equally important and treatment must take into consideration the whole person-his mental and emotional welfare as well as his deep – seated spiritual needs.

Emphasis in the Best

5.5 The maximum advantages of modern medicine are possible only through comprehensive healthcare encompassing the best medical staffs, working in close harmony with its hospitals; the most highly trained personnel, the most advanced life-saving equipment, the most up-to -date facilities and the widest possible range of services.

Consideration for Employees

5.6 The loyalty and enthusiasm of its employees are among its most valuable assets and realising this, the Government seeks to provide fair compensation, excellent benefits and working conditions and a chance to advance in accordance with skills and ability.

Stress on Training and Continuing Medical Education

5.7 Training and Continuing Medical Educational programmes must be perpetuated and expanded to train health personnel for today and for the future, serving the best interests both of hospitals and the community

Interest in research

5.8 Research is essential for life and health in support of this belief, the Society maintains and furthers major research projects and constantly explores additional areas of interest in which to establish activities for the eventual betterment of others.

Concern with Costs

5.9 The patient comes above all and must receive the finest care at the lowest cost consistent with quality and equity.

Responsibility to the Community

5.10 Government hospitals must be responsible to its citizens, participating in activities, projects and organisations which strive to improve the quality of life wherever they exist.

Cooperation with Others

5.11 The voluntary health system must be preserved and strengthened and consequently, the Government (Dept of Health & Family Welfare) devotes its best energies to championing the cause of hospitals throughout the State and in joint planning to avoid duplication and unnecessary expense so that community health needs may be met most effectively and efficiently.

Belief in Excellence

5.12 There should be a constant striving toward excellence and the Government (Dept of Health & Family Welfare) seeks to achieve this through dynamic management coupled with a sense of participation and responsibility by individual employees, aiming at the highest possible standards of performance in all endeavors.

Features of Proposed Organisation Structure

5.13 The key features of the proposed organisation structure keeping into consideration the principals behind it are :

- The proposed structure introduces two main cadres from the Taluk level namely, the Public Health Cadre and the Medical Cadre. This provides equal opportunity for promotion and growth for the clinical as well as public health specialists
- A hierarchical structure has been defined at the senior levels facilitating focus on planning and strategic issues.
- The proposed reporting structure incorporates program based hierarchy. The program officers at the district level to report to Zilla Parishad directly (administratively) and to have more financial authority and to report functionally (for technical inputs and coordination with others) to DHO and respective JD of the program.
- Various positions are re-organised within the DHFW to facilitate streamlining of reporting relationships and functions
- The proposed organisation structure has abolished the post of the DJD
- Opportunities are provided in the proposed structure for continuing service in rural areas without loss of pay benefits
- There is a position created in the proposed structure for specific thrust of health development in Northern Karnataka regions

- The proposed structure recognizes the imperative need for a focused and dedicated approach towards training for personnel and has for this purpose divested the role to an autonomous training body (SIHFW).

- The various externally aided projects have been moved into the mainstream structure thereby converting them to the program mode of implementation rather than project mode. This will facilitate high acceptance of the various programs across the DHS office and District offices

Proposed Organisation Structure

5.14 The proposed organisation structure is discussed in detail under the following heads :

- District Structure
- Divisional Structure
- Directorate Structure

District Structure

5.15 The district structure will administratively be under the control of the ZP while functionally it will be under the DHFW. The recommendations on the district structure are given in the ensuing paragraphs.

Introduction of Public Health Cadre at the District Level

5.16 Emphasizing the need for additional thrust to Public Health and equal promotion opportunities for the medical wing, it is proposed to introduce two distinct cadres from the Taluk Level. This proposal is outlined below :

- The entry level for the medical officer in the Department of Health & Family Welfare is the post of Medical Officer (Primary Health Centre). The minimum requirement for this post is an MBBS degree. This is true for all candidates irrespective of whether they have postgraduate degree as added qualification.

- The specialists will be categorized into two distinct cadres namely,
  - Public Health constituting of personnel holding Post Graduate Degree/Diploma in
    - Public health
    - Community Medicine
    - Health Management
    - Any other equivalent programme as decided by the DHFW/MCI/ GOI/Health University
  - Clinical specialists such as personnel holding Post Graduate Degree/Diploma in various clinical specialties such as

- Opthamalogy / ENT
- Pediatrics
- Obstretics and Gynecology
- Intenal medicine
- General surgery
- Hospital Management
- Any other equivalent programme as decided by the DHFW/MCI/ GOI/Health University

- For promotion to taluk level the following scenario will be applicable: However, the recruitment of specialists will be based on the needs of the department.

- For MBBS + PG clinical specialisation) – allocation to medical cadre – minimum of 2 years of service at Primary Health Centre level to which growth will on the clinical side. (Specialists who enter the service under direct recruitment may be posted to CHC's need based after probationary period at the PHC level)

- For MBBS + PG (Public Health) – allocation to minimum three years of cadre service and subsequent growth will be on public health side.

- The MBBS medical officers will have the following options :
  - Acquire Post Graduate Degree/Diploma qualification while in service at the PHC and follow the growth path of the specialists
  - Promotion avenues in the GDMO cadre upto the District Hospital as a family physician
  - Continue service in the PHC as a Family Physician with time bound scale extensions/gazetted promotion that will be on par with their peers.

Another future option in the coming years may be for MBBS graduates to directly take PG Specialisation in Health or Hospital management only. A career planning and promotional avenue will be needed to be worked out by suitably modifying the C & R rules. These Doctors will be suitable for the managerial positions taluk level upwards.

5.17 An appropriate structure in terms of numbers of specialists in each cadre will need to be designed by the DHFW. This should be done taking into consideration equality in growth pattern and promotion opportunities across the cadres. (certain studies done internally to the organization like Halagi report may also be considered for any review in the system)

5.18 Lateral entry for certain specialists posts such as Anesthetist, Pathologist, Radiologist, etc may be considered for lateral entry at Taluka / District Level, failing which a provision may be created for contractual positions. However these Specilaists will also need to fulfill probationary period of one year at Primary Health Centre for field experience. The cadre and recruitment rules will have to be suitably modified after seeking legal opinion on the same.

5.19 The above proposal is depicted in Exhibit 5.1

Exhibit 5.1

5.20 Alternatively the DHFW could consider introduction of the above sub-cadres at the PHC level, after determining the effectiveness of such a structure.

Organisation Structure at the District Level

5.21 Keeping in line with the above mentioned proposal, the proposed growth path of medical personnel at the district level is depicted in Exhibit 5. 2

Exhibit 5.2

Sub-Centres

5.22 The sub-centres will continue to have the existing structure with the Female Health Worker and the Male Health Worker carrying out the functions of registering the cases of pregnant women, administering immunisation dosage and attending to minor ailments and first aids and refer to PHC, the cases beyond their competence. These personnel will report to the Medical Officer at the respective PHC.

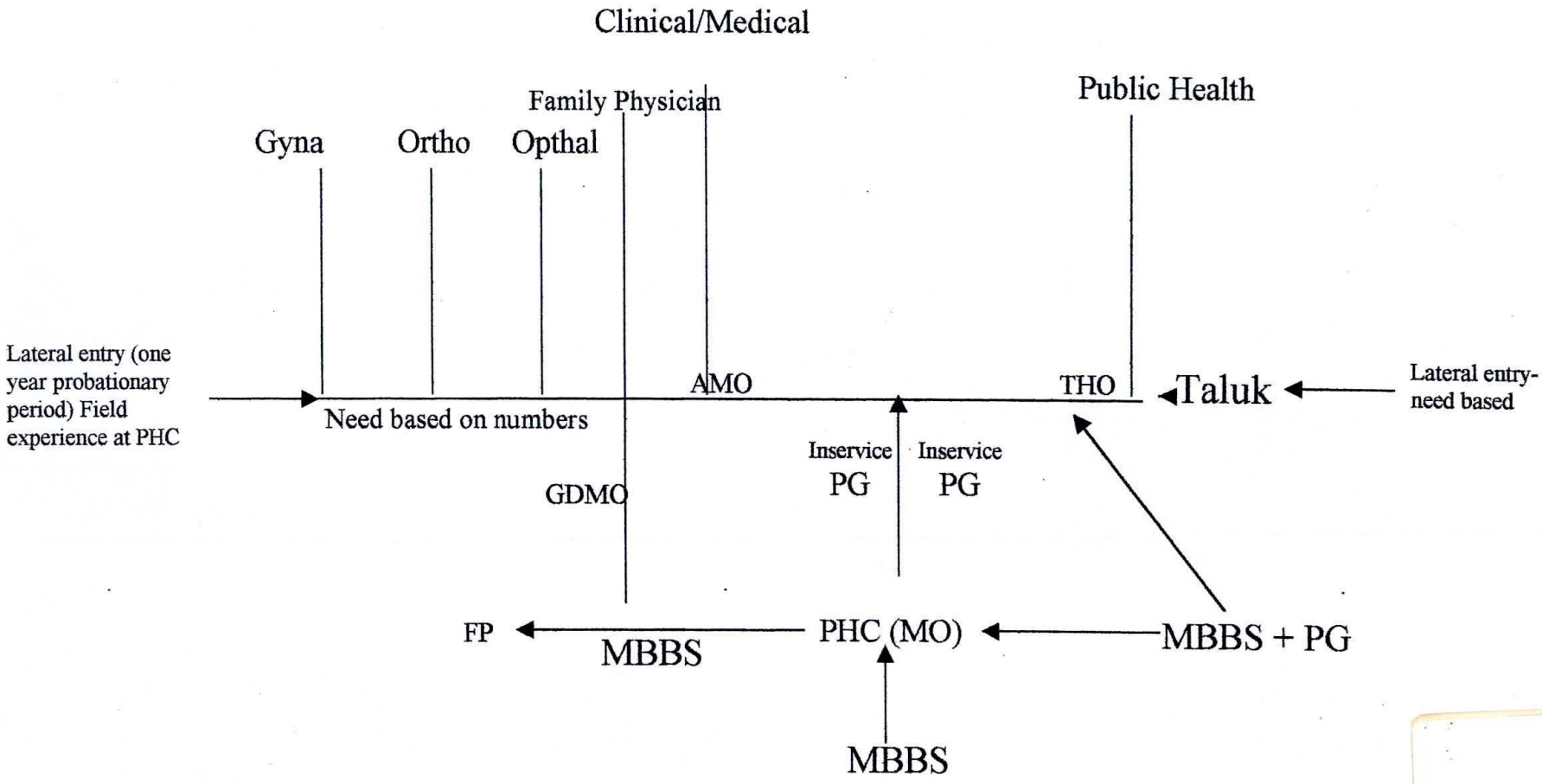
PHC Structure

5.23 The PHC will have at least two Medical officers (incl. one lady medical officer) with the senior Medical Officer being the administrative head. These medical officers will have a team of one Pharmacist, Junior and Senior Health Assistants, a Lab Technician and related support staff. All these staff report to the Administrative Medical Officer.

The Jungalwalla Committee report of mid seventies had suggested Public Health Officer at the PHC level in addition to a regular Medical Officer for public health work. This could be implemented with the Task Force of Govt. giving serious thought to this suggestion of clinical / public health cadre starting from the PHC level itself and both the streams having their own seniority list.

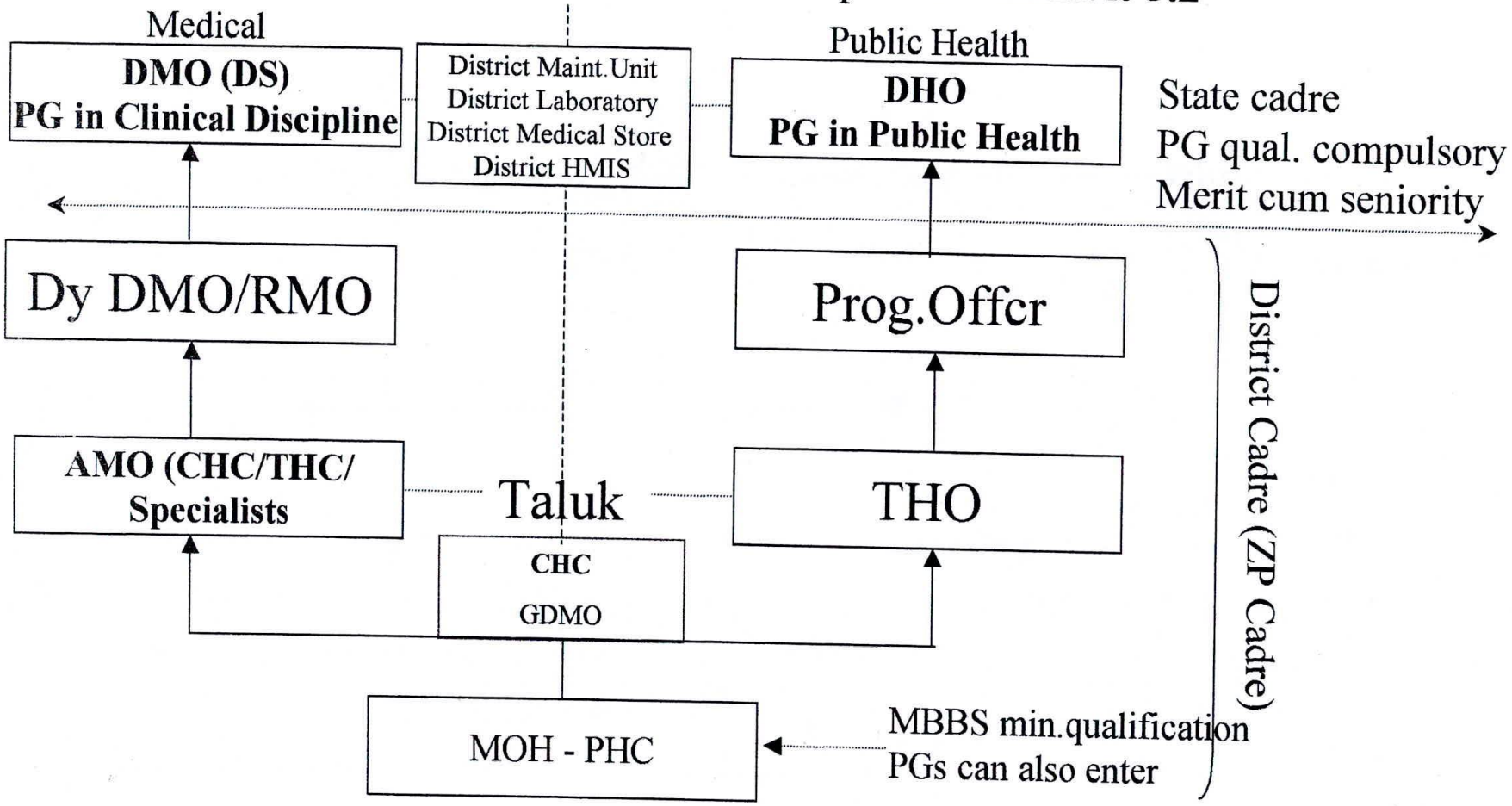
A composite primary health care concept will now consist of one CHC with 3-4 PHC's. The specialists of the CHC will assist the PHC Staff in the execution of public health activities under the guidance and monitoring of the Taluk Public Health Officer. The routine clinical work of the specialists at the CHC will be monitored by the AMO of the CHC.

Exhibit 5.1


Clinical/Medical
Family Physician
Public Health
Gyna
Ortho
Opthal
Lateral entry (one year probationary period) Field experience at PHC
AMO
THO
Taluk
Lateral entry-need based
Need based on numbers
Inservice PG
Inservice PG
GDMO
FP
MBBS
PHC (MO)
MBBS + PG
MBBS

District level - Department of Health & Family welfare

Organization structure - Proposed : **Exhibit 5.2**



CHC/Taluk Hospital

5.24 As discussed in the earlier paragraphs, the distinction between Public Health and Medical is initiated at the Taluk level. Each of the two streams will have their own infrastructure and will draw upon the other's resources in terms of consultation and expertise. Thus, the medical specialists will primarily be responsible for providing clinical care to the patients of the hospital and the public health specialists will be involved in implementation of the various health programs initiated by the DHFW. The common seniority list of PHC entry level will have to be reworked with 2 independent seniority lists of Medical Public health.

5.25 In the medical wing, the specialists will look after curative work. A THC/CHC will be headed by the Administrative Medical Officer-CHC (AMO). The post of the AMO will be a promotional post from the Specialists post. Among the seniors of the AMO's of the Taluk, there will be a Taluk Medical Officer (promotional post) who will monitor and evaluate all the CHC's and Taluk Hospital.

5.26 The Taluk Public Health Officer (TPHO) will head the public health wing of Taluk and will have Public Health officers and program officers, assisting him to carry out various national and state national programmes. These are monitored by district programme officers who in turn report to Zilla Parishad (administratively) and DPHOs & concerned JDs (functionally). TPHO must have a public health PG qualification (atleast DPH) . He will be assisted by Taluk Health assistants (promoted Jr/Sr HA 's from the PHC level), Block Health Educators, Assistant Statistical Officers for HMIS, Refractionist and clerical staff.

District Hospital/DPHO office

5.27 The District hospital will conduct the functions of clinical service. The district hospital is headed by the District Hospital Medical Superintendent and is supported by the RMO, specialists and other staff. The district office will also have a post of the District Medical Officer (DMO) who will look after all medical hospitals (CHC's and TLH,DH) in the district other than the district hospital. The DMO is a promotional post and he will be the senior-most specialist with managerial/ administrative qualifications and experiences. This cadre is above the District Surgeon & necessary C & R rules will have to be framed. Similarly the DHO post will also be upgraded. The senior most programme Officer becomes the DHO.PG qualifications in public health is must for this post. He must have additional managerial/ Admininistrative Qualifications & experience, necessary C & R rules to be framed.

5.28 A detailed work motion study may be carried out for the DHO and indepth analysis to be carried out about his time utilisation. Based on this report a necessary GO in Consultation with the ZP authorities to be framed permitting the DHO to attend only the most important meetings. Programme Officers at District level to be given more autonomy (financial and administrative) with technical directions from the DHO. These officers should be accountable financially also for their respective programmes to the ZP. Presently only DHO operates all the financial matters. Suggest a joint account of Programme Officer with another ZP official to use the programme funds effectively. Details need to be worked out on the monitoring of these issues.

5.29 The DHO which is upgraded as a promotional selection post will be assisted by a ADHO who will be the senior most programme Officer. ADHO will represent the DHO at the ZP meetings and also his major responsibilities will include health planning (micro planning at District level) with implementation / monitoring of HMIS. The Gulbarga and Belgaum Districts will have 2 DHO's each in view of the large size of the District and number of PHC's.

5.30 The following Programme Officers will report to the ADHO for smooth functioning at the District level : a) DLO with STD/HIV b) Health Promotion with 2 Officers (one for nutrition – new post and other for health education – DHEO) c) RCH d) Vector Borne e) TB Officer . Programme Officers for urban health and STD/HIV can be added later as and when these programmes are launched.

5.31 The District Surveillance Officer with his staff of the District Lab etc ., the District Pharmacist – warehouse incharge , District Maintainance Unit for vehicles, equipment and civil will report directly to the DHO for efficient and smooth functioning and monitoring.

Both the DHO and DMO will be responsible for an efficient surveillance system of communicable diseases and referral systems respectively in their areas of operations

The DHO and DMO will be trained in applying epidemiological skills for microlevel planning to the dynamic and changing health scenario both at the public health & hospital lelvel.

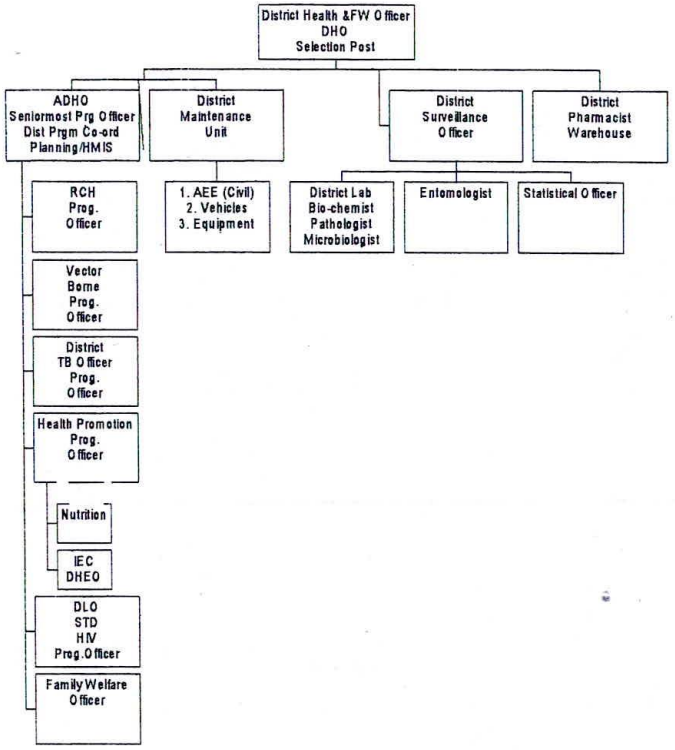
5.32 Though the District Public Health Officer and District Medical Officer / District Surgeon are made to belong to state cadre, it is observed that they cannot escape the influence of Zilla Parishad for having to work in the same territory and for obvious reasons to work closely for common mandate. But, in the present reporting standard, the DHO represents the DHFW in all the meetings of Zilla Parishad, including the ones not about health programs. It is proposed that the DHO may not attend such programs and the authority levels of district programme levels have to be enhanced to be accountable to Zilla Parishad directly.

5.33 The DMO will be a promotional selection post. His office will be located within the District Hospital. The Medical Suptd. (earlier DS) of the District hospital , all the Administrative Medical Officers of the CHC / Taluk and other hospitals in the district will report to the DMO.The DMO will monitor the quality of care in all the hospitals in the district. The Program Officers for Ophthalmology and NCD will also report to the DMO. Presently there will be a separate program officer for Ophthalmology and a combined Program Officer for CVS / Diabetes/ Mental Health / Oncology of the rank of senior specialist till these programs are launched as independent programs with funds allocation. The physician at the District hospital will monitor the TB Centre in the District hospital in coordination with the DTO. Training in public health and program management will be given to all Program Officers. The DMO will also have a maintainance unit of civil, equipment and vehicles under him.

5.34 The proposed re-organisation of the district level structure is depicted in Exhibit 5

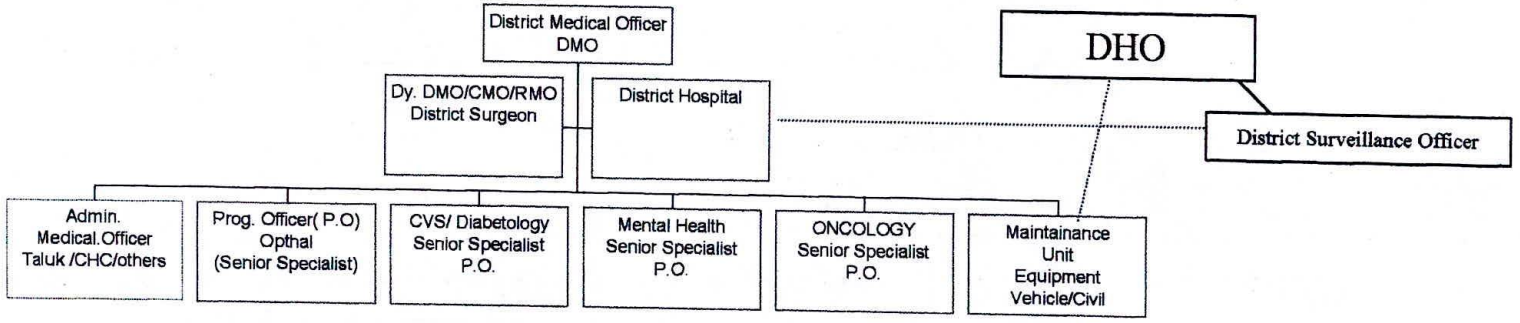
Proposed Org.Structure at District Health Office

Exhibit 5.1



Note: The District Lab staff - Microbiologist/Bio-chemist/Pathologist will be shared by the District Surveillance Office and the District Hospital

District Medical Office - Proposed



Divisional Structure

5.35 As discussed in the previous chapter, the DJD post has become redundant in light of transfer of all district level supervision to the ZP and is recommended to be abolished. It is proposed that the various district level officers under the DJD will report functionally to the respective Joint Directors and administratively will continue to report to the ZP..

Directorate Structure

5.36 The Directorate of Health will be headed by Commissioner / Directorate General of Health Services (DGHS), who will report to the Principal Secretary. The proposed directorate structure is shown in Exhibit 5.5

Commissioner / Director General of Health Services

5.37 The main function of the Commissioner of Health and Family Welfare presently filled by IAS Cadre Officer) to bring about better internal and inter-sector co-ordination and to achieve a greater degree of accountability in health services both in financial and administrative terms. The key activities of this post are :

- Monitoring, supervising and implementing all National and State health and family welfare programmes in the State
- Ensuring co-ordination among the various directorates and divisions within the Health system and also with related departments

It is proposed to rename the Commissioners Post to Director General of Health Services - DGHS to be held by a Senior Technical Officer of the Dept who has risen from the ranks. Also this is a selection post

5.38 The key qualifications for this post (DGHS) will be managerial, administrative and financial skills as well as health systems exposure to carry out their functions effectively. In the current DHFW, it is observed that there are hardly any health personnel skilled in managerial/ administration and related areas. Moreover the exposure to government functioning is minimal. It is proposed that the senior personnel of the DHFWS are given opportunities for attaining the requisite skills such that they meet the qualifications of this post. Till such time, it is proposed that the Commissioner (of IAS cadre) continue to hold the post till such time a suitable technical person is available to fill the post of DGHS.

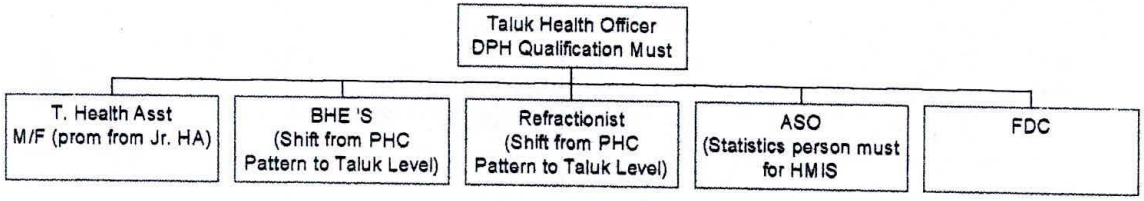
Reporting Structure to Commissioner/DGHS

5.39 The Commissioner/DGHS will have the following functional heads reporting to him:

- Director – Medical
- Director – Public Health
- Director – External Aided Projects

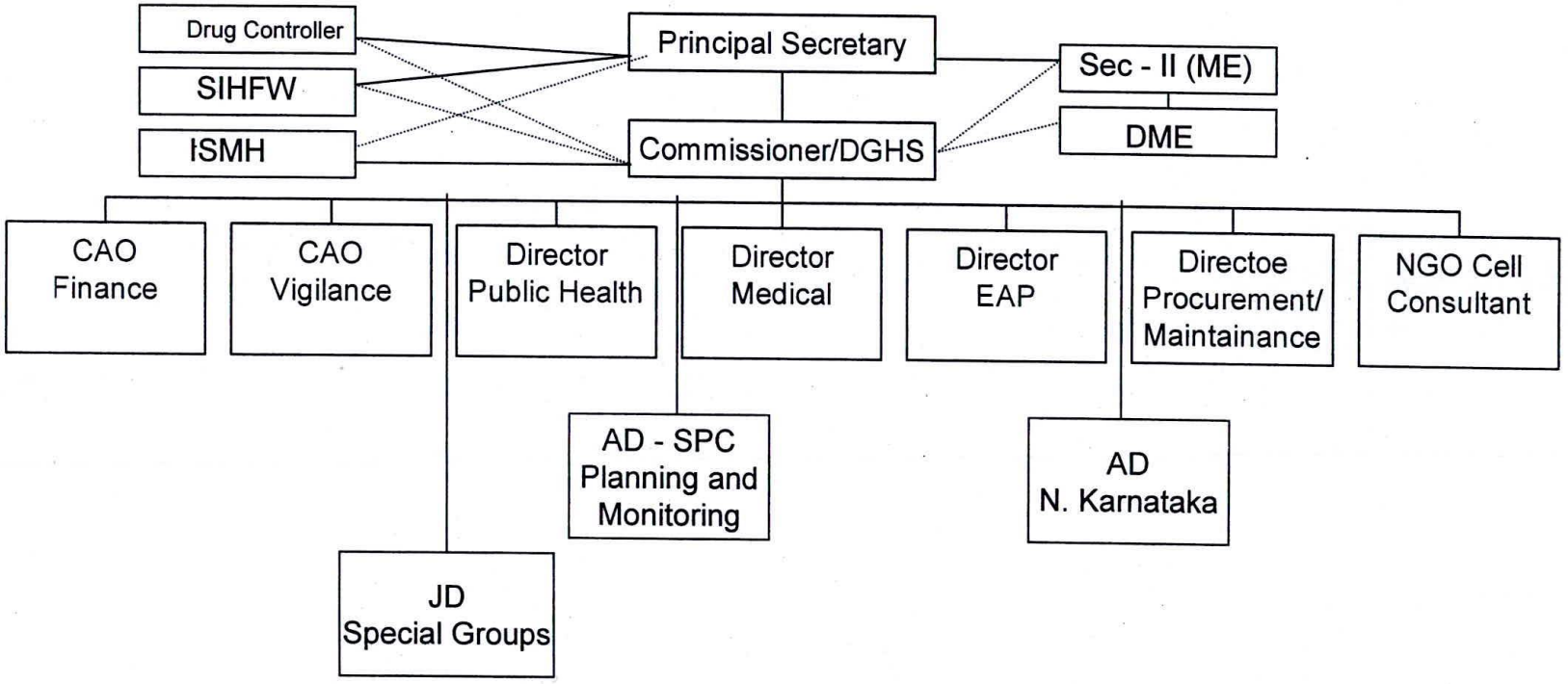
Organization Structure at District Level - Proposed

Taluk Health Office - Proposed

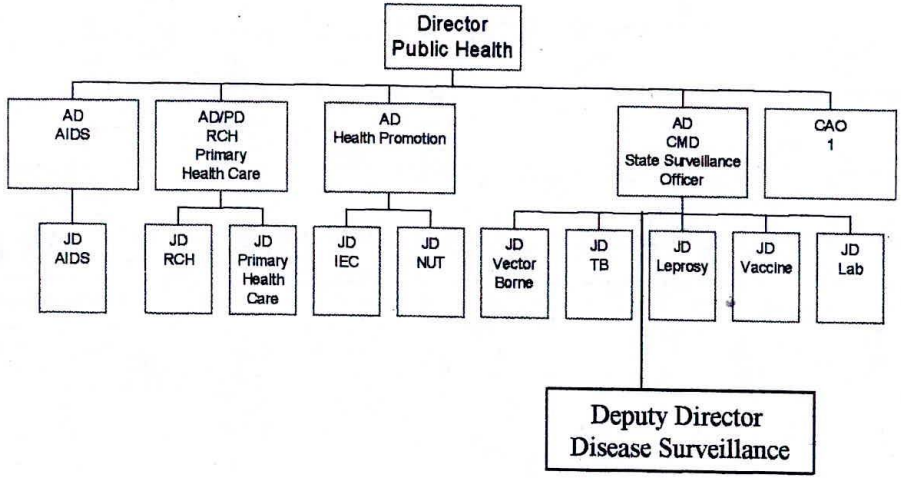


Proposed Org.Structure DHFW

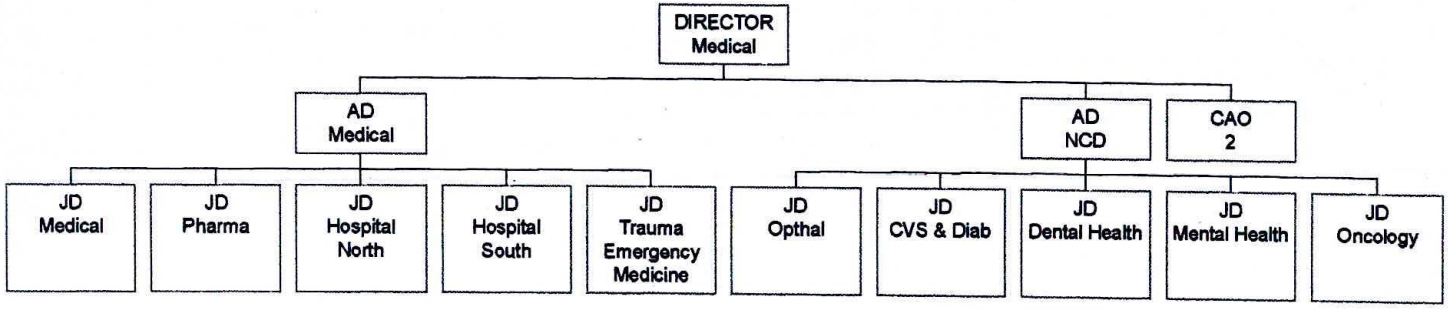
Exhibit 5.5



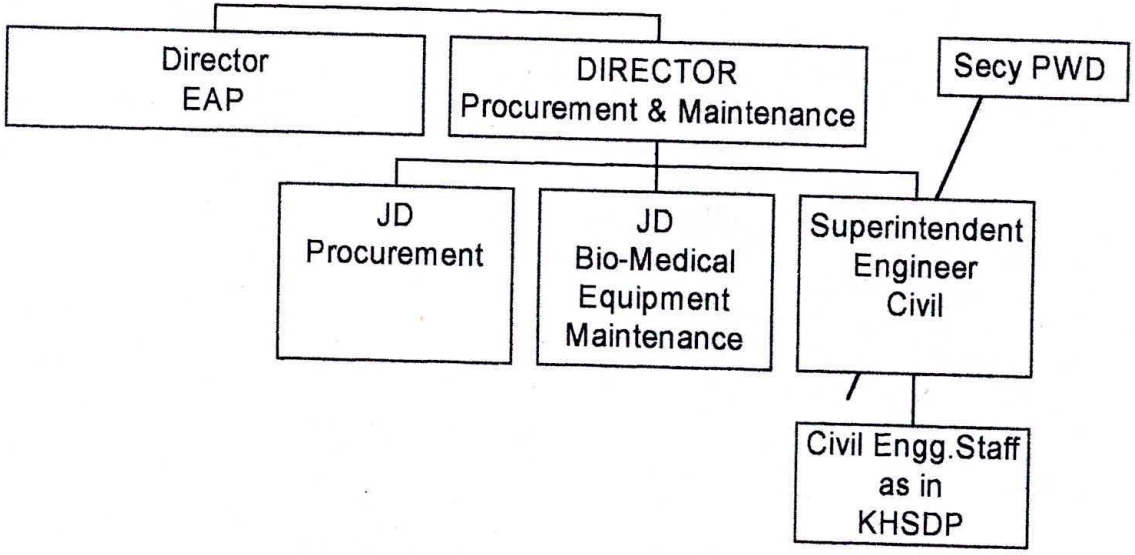
Proposed Health Org.structure at HQ



Proposed Medical Org.Structure at HQ



Proposed HQ Org. Structure



- Director – Procurement and Maintenance
- NGO Partnership Cell
- AD – Planning
- AD – North Karnataka
- CAOs (Administration I & II, Finance and Surveillance)

5.40 This division of work among the key functions of Commissioner / DGHS keeping in view the dynamic nature of the work and effective monitoring of the activities. The structure and functions of the office of each Director's office are discussed below:

Public Health Vs Medical

5.41 Continuing the proposal for two main cadres namely Public Health and Medical at the District level, it is proposed to have a similar structure at the Directorate. Thus, he key preventive, promotive and curative functions of the Directorate of Health are divided split among two directors, i.e. Director – Medical (for curative and clinical services) and Director – Public Health (Preventive and promotive services).

5.42 This will ensure equal commitment from the Directorate to the District for both Public Health as well as Medical. Further, it will provide focused supervision in each of the areas. It will also address the promotional opportunity to each cadre to be their respective Directors

Director – Medical

5.43 This functionary heads the clinical and curative services of the Directorate of Health. The Director – Medical is reported to by two ADs, namely, AD – Medical and AD – NCD.

5.44 ***AD-Medical :*** The AD- Medical currently exists in the KHSDP and due to need for integration between externally aided projects and the DHFWS, it has been brought under Director – Medical. The AD – Medical will look after the Hospital and Hospital management aspects in the Directorate. He will ensure that a proper referral mechanism is in place in the state to ensure speedy treatment at various levels of hospital care. This post will be assisted by the following JDs:

- JD – Medical
- JD – Hospital
- JD – Pharma

5.45 The JD – Hospital is a new post created for focused supervision of hospitals under the DHFWS. The JD (GMS) has been re-named to JD (Pharma) with emphasis on distribution of drugs and pharmaceuticals. The detailed reporting relationships and duties and responsibilities of the above are provided in Volume II of this report.

5.46 ***AD-NCD:*** To bring about greater emphasis and co-ordination in identification and treatment of Non- communicable diseases, it is proposed to have an AD post who would look after non-communicable diseases likes Cancer, Opthalmology, Diabetes, etc. In addition, it is proposed to have the following JD posts reporting to the AD-NCD :

- Joint Director – Opthalmology
- Joint Director – NCD (Cardiovascular and Diabetology)
- Joint Director – Emergency Medicine / Traumatology
- Joint Director – Mental Health
- Joint Director – Oncology
- Joint Director – Dental Health

5.47 Recent studies Murray & Lopez: WHO and other reports – Nimhans, AIIMS, NCAER etc) have shown the rising incidence of NCD cases. This will necessiate that the Dept of Health have senior officers of the rank of JD's in each of these specialiities to monitor the identification,curative, preventive and promotive aspects of the NCD's.

5.48 Taking into consideration the future requirements of Health care delivery, it is proposed to have focussed attention in these areas. The various JDs will primarily be responsible for the curative and research aspects of these specialisations. The detailed reporting relationships and duties and responsibilities of the above are provided in Volume II of this report.

Director – Public Health:

5.49 The Director –Public Health will be overall in-charge of the Public Health development in the State of Karnataka. He will utilize his resources for effective implementation of the various National and State level public health programmes. He will be assisted by the following ADs :

- AD - RCH / Primary Health
- AD – Health Promotion
- AD – CMD
- AD – AIDS

5.50 ***AD -RCH*** is an existing post and will continue to perform the current key functions. He will be assisted by the JD – RCH. He will also look after Primary Health Care which is essentially a part of RCH and assisted by JD – PHC.

5.51 ***AD – Health Promotion:*** The current AD (HET) is renamed as AD – Health Promotion and will handle the functions of Information, Education and Communication (IEC) along with other health promotional activities. He will be assisted by the following JD:

- JD – IEC
- JD – Nutrition (new post)

5.52 JD (IEC) currently is under AD (RCH). As the main function of the JD (IEC) relate to communication of health related programs to the public it is proposed to re-locate this post to be under AD – Health Promotion. Thus, bringing all health communication activities under a single head will facilitate higher level of integration and maximum utilization of resources.

5.53 ***AD – CMD*** is re-located from the KHSDP and will supervise the activities of various national and state programs relating to vector borne diseases, TB, Leprosy as well as the Vaccine Institute and the Laboratory. Each of the above functions are managed by the Joint Directors. He will be nodal officer for the State surveillance Unit, the detailed job description is in Vol II of the report. The JDs reporting to AD- CMD are :

- JD -Vector Borne
- JD – TB
- JD – Leprosy
- JD – Vaccine Institute
- JD - Labs

5.54 The JD (Vector Borne) post is renamed from JD – Malaria & Filaria with the scope to incorporate additional vector borne diseases.

AD – North Karnataka

5.55 In view of the existing backwardness in the districts specified in terms of the medical & public health standards, there is a need in the DHFW for focused attention on the development of this region. It is proposed to have a post namely AD – North Karnataka, held by a senior person with exposure to both public health (programme management) as well clinical, reporting directly to the Commissioner/DGHS).

5.56 The key role of this post will be to monitor the Dept. Of Health & Family Welfare activities at Bijapur, Raichur, Gulbarga, Belgaum, Bidar, Bagalkot, Bellary, Koppal ,Gadag districts. His office acts as a nodal office for all the activities of Dept. Of Health & Family Welfare. He acts as a coordinator between different functionaries in the department and also liaison with the directorate on behalf of the districts mentioned. (detailed job description is given in Vol II of the report)

AD - Planning

5.57 The need for integration of planning at the Directorate Level necessitates a post of AD - Planning (reporting directly to Commissioner / DGHS). This post replaces the existing Strategic planning Cell and will take up the activities of long-term ,short-term and perspective planning for the department, with the inputs from different national and international agencies as well as the Management Information Systems (MIS) functionary of the department. He will monitor the changing epidemiological profile, the burden of disease, recommend cost effective measures to achieve best use of limited resources. Also carry out studies on a continuos basis and interpret , analyse trends initiate policy initiatives for reform and change. Will also review the annual plans, five year plans and MMR. Will edit the annual report of the department. He will be assisted by the following personnel :

- JD -MIS
- JD -Planning

5.58 The JD –MIS will be the nodal point for all information relating to the DHFWS. He will collate information from all medical, hospital and public health functionaries in the department and interprets for any inferences or corrective actions. The bureau of health intelligence, demography cell and all statistical units in some divisions will function under the JD (MIS).

5.59 The JD (Planning) will be the nodal Officer for preparation of annual plans, five year plans and annual report of the department. Detailed JD's are in volume II of the report.

Director – External Aided Projects

5.60 The various operations of the Externally Aided Projects is proposed to be conducted in the main stream of the DHFWS. However, a need was felt to introduce a functionary reporting to the Commissioner/DGHFW to oversee the management of these projects and to handle any co-ordination with external agencies, if any. The Director – EAP will have the following key functions :

- Monitor all the existing External Aided Projects, if needed by having different reporting authority for each. He stands the overall responsibility for the financial accountability of the Projects
- Identify new areas of collaboration with other agencies and bring them to reality.
- Work in close association with mainline department in carrying forward the objectives of all External Aided Projects with a programme mode of approach rather than a project mode.

Director – Procurement and Maintenance

5.61 In the current structure, the procurement and maintenance of various equipment and civil works are distributed across the various departments. It is proposed to centralize these activities by creating a separate cell reporting to the Commissioner/DGHS. It is proposed to place an IAS person to head this department since this is administratively and technically the key functionary for the department. He will be assisted by the following people:

- JD – Procurement
- JD – Equipment & Maintenance (Bio-Medical)
- Chief Engineer – Civil

5.62 JD – Procurement's key functions include receiving the indent for any equipment from all respective functionaries in the department about their requirement, placing tenders for acquiring those equipment and finally acquiring them from the most feasible bidder. The person to hold this position can be one with engineering/logistics background since it involves appraising of tender documents, acquiring equipment and supplying to the destined location . He should be well versed in all the procurement procedures of World Bank and other funding agencies.

5.63 JD – Equipment and Maintenance (Bio-Medical) takes care of all the machinery and equipment including the vehicles of Directorate of Health Services. He will be assisted by

- DD – Equipment
- DD – Equipment (training)
- DD – Transport

These posts are already existing under KHSDP and same to be transferred to the Directorate of Health and Family Welfare.

5.64 Chief Engineer – Civil has functional reporting to the Secretary – PWD and administrative relationship to the Commissioner through Director – Procurement. He is incharge of all the civil related construction and maintenance work of the Directorate of Health services. He appraises the tenders for construction and allots the work to the eligible persons. He is assisted by

- Superindent Engineer – Civil
- Dy. Cheif Architect

Director –SIHFW

5.65 Currently, he is a functionary reporting to Project Director – IPP – IX. It is proposed that henceforth he will head the training function of the department and SIHFW which will be a Autonomous and report functionally to the Principal Secretary of Health. The hierarchy of the proposed structure of the office of Director SIHFW includes:

- JD
- DD
- District Training Officers
- Other training personnel involved in training in Health & Family Welfare throughout the state

NGO Partnership Cell

NGO participation in Health Care has become very essential at levels of Public Health Care and first referral. These need to be supported and encouraged with special focus esp. in the backward and remote region of the State. A number of NGO are registered with the Health Department under various schemes and various programmes. It is important that all NGO's have a single source of interaction, coordination with the Health Department. It will also enable the Government to monitor and evaluate the activities of the various NGOs participating with the Health Department. Hence it is suggested to have a NGO Partnership Cell as a single window in the department headed by preferably by a Advisor/ Consultant to coordinate the activities of this cell with the Commissioner/ DGHS to simplify procedures for grant in Aids avoiding delays.

Joint Director (Special Groups)

A new post needs to be created to cater to the problems of women (gender sensitivity ,Tribals, Elderly and the Disabled). He will report directly to the DGHS and coordinate with other departments and sectors.

Benefits of proposed structure

5.66 The key benefits of the proposed structure are outlined below :

- The structure is Programme based thereby leading to more accountability for programme officers from Taluka level itself
- The split of DHFW functions into Public health and medical for better monitoring and execution of duties and responsibilities, thus increasing the scope for accountability at each stage

- Equal promotional avenues for all medical professionals in the department
- Scope to have seniority cum merit during promotions
- Removal of divisional structure, leading to concentrating the activities at district level
- Direct monitoring of all national and state programs from the directorate itself, thus paving way for better coordination among districts and with the directorate

5. Review of Existing Cadre

5.1 The study involved determining the various cadre-related concerns as expressed by the personnel met during detailed discussions and offering suggestions for the same. In addition the cadre and recruitment rules were reviewed in brief to determine conformance to the proposed structure. This cadre review is presented under the following :

- Introduction of sub-cadres
- Promotion, Postings and related Policies
- Qualification and Training
- Private Practice
- Adherence to working hours

Introduction of Sub-Cadres within Specialist cadre

5.2 As proposed in the previous chapter, the DHFW has two distinct cadres namely Public health and Medical. One of the considerations taken into account was the introduction of sub-cadres for the various specialists under the medical cadre. The drawbacks of such a consideration are :

- Complex cadre management
- Blocking of levels based on growth
- Skewed requirement across specializations

5.3 There is thus a need to determine senioritis and growth path for each sub-cadre and its implementability and acceptance prior to introduction. In the interim it is suggested that the DHFW determine the number of posts under each specialization instead of introducing sub-cadres. Identify the need for specialists in the state and thereby send doctors to acquire postgraduate qualification in those specializations only. This will avoid mismatch of specialists to number of posts in the department.

5.4 The DHFWS has already identified the posts of Dy Chief Medical Officers/Senior Specialists/Senior Medical Officers/Specialists and General Duty Medical Officers in April 1993 and documented the same in an official memorandum (No 378). This can be used as a reference for determining the number of posts at each specialist post. Subsequently, it was reworked recently. And known as Dr. Halagi report which is yet to be accepted by the Government for implementation.

Promotion, Postings and Related Policies

5.5 The existing policies on promotion, postings and related areas have been reviewed in light with the current issues faced by the various personnel and our proposed organisation structure.

Postings

5.6 It is the view of a cross section of personnel in the DHFW that very often postings though accepted by the candidate, are subsequently not filled up mainly due to :

- State cadre recruitment leading to selection of urban candidates (specifically women candidates) who are unwilling to take up postings in rural areas
- Unwillingness to withdraw from offer as they are sure of getting a posting of their choice

5.7 This leads to a lot of posts being vacant for long duration's thereby defeating the very objective of DHFW of continuous health care especially for the rural areas.

5.8 Suggestions to the same were offered in terms of introduction of criteria of native place/permanent residence of candidate in the merit determination specifically for postings for rural areas. However, this may lead to the higher merit candidates not getting opportunities in the place of their choice. It is suggested that a counseling form of posting the candidates (similar to the CET counseling) be introduced with the following measures :

- Mandatory rural posting for a minimum defined period in the initial years of service (e.g two years)
- Posting once accepted cannot be revoked except under extra-ordinary circumstances such as on medical or humanitarian grounds (which need to be clearly stated and proved)– any attempt to do the same to result in expulsion from service

5.9 A move towards district recruitment for the district cadre was considered and the view was that this would lead to certain issues such as imbalance of posts required vis-à-vis available candidates in the district and lesser opportunities for merit candidates resulting in the decision for central recruitment policy with counseling. DHFW will need to review the legal implications for implementation of counseling mode of posting

Specialty based Posting

5.10 The postings at the various CHC/Taluk Hospital and District hospital should be done taking into consideration the various specialties at these centres and their requirements.

5.11 Specialisations of the various candidates need to be considered during postings. Currently for example Orthopedic specialists are posted at PHCs where there are no facilities to provide their specialists service in addition to the routine PHC activity. Further, additional qualification attained by the candidates between application to service and joining DHFW is recommended to be considered while posting.

5.12 The posting policies should also incorporate specialization based requirements at each health centre. E.g. currently there are surgeons posted in hospitals without

anesthetist, three ENT specialists in a one centre while there are no surgeons etc leading to mis-match between requirements and postings.

Promotion/Transfers

5.13 Currently transfers are mostly promotion based, which is on the basis of seniority. It has been observed that very often the promotion/transfer mechanism is not effective due to the following factors :

- Lack of rotational transfers
- Non-conformance to transfer order
- Consideration of pending service period prior to transfer

Promotions Table

	Village	SC	PHC	CHC	TLH	District	State
Trained.Dai		ANM					
JHA-F/M		JHA F/M	SHA F/M		THA F/M	DHA F/M	
Staff Nurse			Junior SN	Staff Nurse	Senior SN	DNO	DD Nursing
Pharmacist			Junior	Pharmacist	Senior	District	Chief/DD
BHE					BHE	DHEO	DD
Lab.Tech.			Lab.Tech	Junior	Senior	Senior	

Rotational Transfers

5.14 The review of cadre policy has brought to light that very often personnel are based in the same health centre for long periods extending upto around 20-23 years. Introduction of rotational transfers will facilitate spread of experience across different regions. Rotational transfers can be done through counseling with the support of manpower planning details.

- Be a part of the team conducting eye related operation, atleast on 15 occasions in a year
- Programme evaluation of blindness control

Training Areas:

- New areas of development in proper eye care
- Exposure to new equipment related to opthalmology
- Programme Management
- Health Management

Job Title: **JOINT DIRECTOR – NCD (Cardiology & Diabetology)**

Reporting To: **Additional Director – NCD**

Immediate Level Subordinates:

- District Surgeon
- Superintendents of major hospitals
- Other specialists in the area of Cardiology and Diabetology

Basic Function:

Overall incharge for the diagnosis and possible treatment of Cardiac and Diabetes related ailments to the people of the state. Monitor the basic referral system in the state with reference to the above mentioned ailments and conduct medical audit of the cases wherever found necessary and asked for.

Duties, Responsibilities and Authorities:

- Conduct different awareness building camps about Cardiology and Diabetes including prevention factors, risk factors and patient education
- Monitor proper availability of life saving drugs related to Cardiology and Diabetes
- Monitor referral system in the state with respect to the above ailments
- Ensure conducting of medical audit for some operations on a sample basis and compulsorily for critical and controversial operations
- Planning, implementation and monitoring of programmes connected with National Programme for control of cardiac cases and diabetic cases
- Identify the magnitude of the problem of blindness cases
- Training of Assistants in the field of cardiology and diabetology.
- Matters pertaining to calling for tenders for drugs, equipment related to cardiology and diabetology.
- Ensure conducting of medical audit for some operations on a sample basis and compulsorily for critical and controversial operations

- Coordinate with District Officers in spreading the message of good nutrition for control of diabetes and cardiac cases among the people of the state
- Review of working of Major equipment
- Continuous monitoring of the performance of the personnel at different hospitals and recommend for any training required.
- Monitor the effectiveness of camps conducted
- Review the hygienic conditions in the operation theaters and wards
- Coordination with NGO's

Main Accountabilities:

- Medical audit of eye operations conducted either at special camps or hospitals
- Visit all hospitals which have the facility for treating cardiac and diabetes, atleast once a year.
- Programme evaluation of control programmes

Training Areas:

- New areas of development in cardiology and diabetology
- Exposure to new equipment related to cardiology and diabetology
- Programme Management
- Health Management

Job Title: **DIRECTOR – PUBLIC HEALTH**

Reporting To: **Commissioner / DGHS**

Immediate Level Subordinates:

- Additional Director – RCH
- Additional Director – Urban Health
- Additional Director – Health Promotion
- Additional Director – PHC
- Additional Director - CMD

Basic Function:

Effective Implementation of all national and state public health programmes. Preparation of a public health policy for the State. Overall responsibility for establishing, managing and development of health infrastructure in the state. Is responsible for the public health services delivered in the state.

Duties, Responsibilities and Authorities:

- Develop a comprehensive strategic plan for the public health wing of the department which includes vision, mission, objectives, goals of the department
- Ensure that quality public health care services are available to the target population
- *Ensure adequate population/bed ratio, physician/bed ratio as per norms is maintained (Government of India / WHO / state government)*
- Ensure that the primary health centers and referral hospitals are easily accessible to the population, review need for rationalisation and relocation of some health units as well as setting up new health units in order to improve accessibility and service coverage.
- Review and evaluate the existing policies and procedures and work methods by means of periodic and special studies
- Review the MIS reports generated by AD – Primary Health / Planning and take corrective actions
- Review and recommend the upgradation of primary health infrastructure in the state
- Work out improved methods and procedures to achieve the objectives and Develop standards, methods and measurements of the PHC activities
- Monitor the utilisation of public health resources throughout the state and adopt means of bringing optimum utilisation
- Ensure periodic health promotion activities (quantifiable) are carried out in the community
- Visit all districts esp PHC's at random and review the Public health programmes in the state, atleast once a year.
- Ensure that medical audit and internal audit has been carried out in as many PHC's as possible at periodic intervals

- Submit all relevant material which can be hosted on the department website
- Ensure that full economy and expenditure control is observed in all public health related operations and activities in the state.
- ***Recommend transfer and postings of District Health Officers.***
- Overall responsibility for the prevention of diseases of any kind and promotion of health throughout the state by training the department cadre
- Monitor each national and State health programmes and their implementation with special emphasis to Maternal & Child Health and Primary Health Care
- Suggest for the continuation or stopping of different national and state health programmes according to the need of the state.
- Monitor the training needs identification of the personnel in the department and nominate for the respective programmes to be conducted by State Institute of Health and Family Welfare or other institutes from time to time
- Monitor the Information, Education and Communication department activities in the state in terms of educating / bringing awareness among the people
- Monitor the treatment and curbing the spread of vectorborne diseases in the state with the coordination of corporations and municipal authorities in the state with emphasis on disease surveillance and epedemiology
- Monitor the norms of blood safety as specified by concerned authorities/boards from time to time
- Monitor the functioning and activities of Vaccine Institute, Belgaum.
- Monitor and Review the methods of combating the spread of Communicable diseases in the state
- Monitor the working of urban health programme and slum improvement programme
- Receive and review the MIS reports on the status of health in the state and take up any remedial actions either in terms of interim review of existing programmes or new programmes.
- Work for the coordination between all the reporting functionaries
- Work for the effective coordination with external and autonomous agencies in implementing the health mandate in the state.
- Monitor effective implementation of various public health programme

Main Accountabilities:

- Visit all districts and taluks which conduct the national/state public Health programmes in the state atleast once in a year

  Address all programme officers in the districts atleast once in a year and appraise them of the expectations of the government and their deliverables

- Ensure quality of care in all PHC's through periodic medical audit and patient satisfaction surveys
- Achievement of Health goals of state
- Ensure optimum capacity utilisation of hospital infrastructure through periodic review of MIS reports (hospital efficiency indicators) of all hospitals
- Increase of health infrastructure (need / technology based) in the state in coordination with planning cell

Training Areas:

- Attend Management Development Programmes at international institutes such as Harvard, John Hopkins, etc in areas of Public Health Policies, health policies, New business models in Health care.
- Study Health care facilities and delivery system in both developed and developing countries and also attend national and international and to share the experiences of Karnataka and get a feedback.
- Awareness of different kinds of Public Health Programmes in the developed and developing countries
- Project execution methodology of international agencies
- Health Management

Job Title: **ADDITIONAL DIRECTOR – RCH**

Reporting To: **Director – Public Health**

Immediate Level Subordinates:

- Joint Director - RCH

Basic Function:

Overall responsibility for all Maternal and child health in the state. Ensure proper implementation of RCH / Family Planning programme in the state

Canalso look after the work of AD – primary health.

Duties, Responsibilities and authorities:

- He is the overall head of the RCH project office of Directorate of Health & FW Services.
- He is responsible for planning of RCH programme
- He is responsible for effective achievement of the laid down projects under FW & MCH programme.
- He is overall supervisory authority for training of various field staff like Dais, Para Medical staff and Medical personnel.

- Coordinate with municipal and corporation authorities in spreading the message of Maternal and Child Health
- He is responsible for acting as liaison between Govt. of India/ Internal agencies like UNICEF, World Bank and State Government for various projects from preparation to implementation stage.
- He is responsible for procuring and equipping the public health institutions and Taluk institutions, with various types of equipment & apparatus for effective implementation stage.
- *Ensure the increase in deliveries in PHC or other hospitals to decrease the risk of infant mortality and maternal mortality*
- He is responsible for monitoring and supervising the activities of the demographic cell, IEC activities of RCH project office.
- Recommend construction of subcenters for RCH programme

Main Accountabilities:

- Visit all district Hospitals, some PHC/CHC's (quantifiable number) and specialty hospitals atleast once a year
- *Ensure the increase in deliveries in PHC or other hospitals to decrease the risk of infant mortality and maternal mortality*
- He is responsible for monitoring and supervising the activities of the demographic cell, IEC activities of RCH programme

Training Areas:

- Programme management
- Health management
- Pediatric care
- Community Health
- Issues in Maternal & Child Health, their addressal in different parts of the world

Job Title: **JOINT DIRECTOR - RCH**

Reporting To: **Additional Director – RCH**

Immediate Level Subordinates:

- Deputy Director – RCH
- Deputy Director – IUD & PPP

Basic Function:

Responsible for proper Maternal and child health in the state. Ensure proper implementation of RCH programme in the state

Duties, Responsibilities and authorities:

- He is the nodal officer of the RCH project office of Directorate of Health & FW Services.
- He is responsible for implementation of RCH programme
- He is responsible for effective achievement of the laid down projects under FW & MCH programme.
- He is overall supervisory authority for training of various field staff like Dais, Para Medical staff and Medical personnel.
- Coordinate with municipal and corporation authorities in spreading the message of Maternal and Child Health
- He is responsible for acting as liaison between Govt. of India/ Internal agencies like UNICEF, World Bank and State Government for various projects from preparation to implementation stage.
- He is responsible for procuring and equipping the public health institutions and Taluk institutions, with various types of equipment & apparatus for effective implementation stage.
- *Ensure the increase in deliveries in PHC or other hospitals to decrease the risk of infant mortality and maternal mortality*
- Implement construction of subcenters for RCH programme

Implementation, monitoring and reviewing of all activities connected with RCH programme, immunization of children against vaccine preventable diseases and other MCH activities.

- Procurement of UIP vaccines, distribution and follow-up of the vaccines & maintenance of Cold chain equipment/ articles.
- Monitor the timely administration of vaccines to pregnant women and infants throughout the state
- Ensure the availability of doctors, nurses and ANMs at the respective hospitals to attend to any kind of medical help regarding Maternal and child health

- Work in coordination with the IEC functionary in spreading the message of Mother and Child Health and the precautions to be taken during pregnancy and child birth
- Submit the reports regularly to the office of AD-planning for developing a comprehensive MIS reports on the status of Maternal and Child Health in the state.
- Supply of material to IEC functionaries regarding the material to be prepared about Maternal and Child Health
- Recommend for construction of RCH sub-centres, postpartum centres and other buildings coming under RCH programmes.
- Payment of Grant-in-aid to the voluntary agencies who are implementing the RCH programme.
- *Coordinate with the office of JD – IUD & PPP to spread the message of RCH*
- Monitor the effective implementation of Universal Immunization Programme.
- *Ensure the increase in child deliveries in PHC or other hospitals to decrease the risk of infant mortality*

Main Accountabilities:

- Increase in deliveries in PHC or other hospitals to decrease the risk of infant mortality and maternal mortality
- Visit all district hospitals atleast once in a year and other community health and primary health centres on a sample basis
- Conduct atleast one meeting of all the district family planning and RCH officers in a year
- He is responsible for monitoring and supervising the activities of the demographic cell, IEC activities of RCH programme

Training Areas:

- Programme management
- Health management
- Pediatric care
- Community Health
- Issues in Maternal & Child Health, their addressal in different parts of the state

Job Title: **DEPUTY DIRECTOR - IUD & PPP**

Reporting To: **Joint Director – RCH**

Immediate Level Subordinates:

- District Health Officer
- District Family Planning Officer

Basic Function:

Overall incharge of family planning operations in the state and implement the national and state level programs in relation to IUD & PPP. Convey the decisions taken at the directorate regarding IUD & PPP programs to the district officials

Duties, Responsibilities and Authorities:

- Responsible for planning, supervision and guidance of IUD programme oral pill programme and All India Hospitals Post Partum Programme under the supervision of Joint Director - RCH
- Provide guidance and supervision to the field operations in relation to Family Planning Programme in State at various levels especially in the field of IUD & PPP and oral pill programme.
- Secure cooperation and assistance of related departments for family planning work at State level.
- Review programme operation from time to time, identify problems, provide help in finding situations and seek assistance of Govt. of India, to solve them when necessary.
- Ensure arrangement to follow up of each case of IUD in the region allocated.
- Maintain administrative liaison with all official and non-official family planning organisations in the State.
- Coordinate with the office of JD – RCH and spread the message about Family planning
- Conduct special family planning camps to men and women throughout the state
- *Coordinate with IEC functionary in spreading the message of family planning and misconceptions about different kinds of family planning methods*
- Formulate field instructions and operative manuals.
- Function as a clearinghouse for up to-date information on achievements and progress in the State as a whole for IUD & IPPP and oral pill.
- Attend to such other items of work as may be assigned and the Joint Director - RCH and other superior authorities.

Job Title: **DEPUTY DIRECTOR – RCH**

Reporting To: **Joint Director – RCH**

Immediate Level Subordinates:

Basic Function:

His office acts as nodal centre for all the districts regarding different national and state RCH programs. Monitors the RCH and particularly the reproductive and child health programs in different parts of the state. Conveys different decisions taken at the directorate regarding the above programs to the district officials.

Duties, Responsibilities and Authorities:

- Work towards integrating maternal & child health and family planning.
- Work in close liaison with the Deputy Director - IUD & PPP and other officers of State Family Planning Bureau.
- Ensure that all maternal and child health staff fulfil their required responsibilities in family planning and that the MCH clinics are equipped with the necessary supplies and facilities for family planning work.
- Assess the in-service training needs of all MCH personnel and arrange for their training.
- Coordinate and guide family planning training in the nurses and ANM training courses to ensure that proper training in family planning is imparted.
- Help to supervise the MCH services to ensure that there are adequate physical facilities, equipment and drugs and to see that proper educational and clinical procedures are carried-out.
- *Convey the decisions taken regarding RCH activities to the district officials.*
- *Convey the suggestions and problems of the district level officials to the JD/AD - RCH*
- Help to guide and supervise proper follow-up of women who have adopted family planning methods.
- Take action to organise the ANM training centres and LHV training centres and see that the centres function properly.
- Arrange to see that selection to the ANM and LHV training centres is done in time and as per rules.
- Arrange to conduct the training according to prescribed syllabus and arrange for conducting examinations periodically and to announce the results.
- Take action to organise the dais training.
- Supervise work of District Nursing Supervisors, check and review their diaries, inspect the work of LHVs and ANMs.

- Take action to organise the programme of immunisation of pre-school children and expectant mothers and prophylaxis against nutritional anemia vitamin A deficiency.
- Attend to such other items to work as may be assigned to him by the Joint Director (RCH) and other superior authorities.

Job Title: **ADDITIONAL DIRECTOR – HEALTH PROMOTION**

Reporting To: **Director – Public Health**

Immediate Level Subordinates:

- Joint Director – Health promotion
- Joint Director – IEC

Basic Function:

Responsible for educating the different functionaries in the department about national and state health programmes. Oversee the Information, Education and Communication activities in the state and their affectivity in reaching to the people of the state with special emphasis to the rural, slum and school children and liasion with different agencies of mass media in the state in spreading the message of health to all.

Duties, Responsibilities and Authorities:

- Liaison with AIDS society in spreading the message of prevention measures against AIDS
- Coordinate with all the functionaries in the Health Department and receive requisitions regarding any kind of spread of prevention message for the public regarding public Health and medical health
- Emphasis of positive health, school health and use of captive audience in hospitals
- Oversee the activities of the publication division of the department
- Review the process of sending requisition of publication from IEC cell to the publisher.
- Set standards and monitor the quality assurance in the publications of the department
- Guide the respective Joint Directors in setting targets to the Health Promotion and IEC cells of the department and attain the goals
- Coordinate with the office AD – planning in generating reports about the status of health in the state and planning for the future in attaining good health standards
- Suggest methods of using the special occasions of melas and exhibitions to spread the message of Public Health
- Monitor the activities involving bringing awareness among the general public and children about the public health.

- Identify the areas of development among the department functionary about public Health and appraise the State Institute of Health and RCH about them and ensure nominating eligible persons as and when such programmes are announced by any institute
- Liasion with All India Radio, Doordarshan and other authorities in spreading the message of Public Health
- Intersectoral coordination with information and broadcasting, labour ,education, women and child department
- Emphasis on patients charter of rights
- Head of State health Education Bureau

Main Accountabilities:

Visit all major exhibitions where the department participates with its stall in it
Public perception of IEC activities

Post programme evaluation

Training Areas:

Mass media education

Job Title: **JOINT DIRECTOR - I.E.C.**

Reporting To: **Additional Director - Health Promotion**

Immediate Level Subordinates:

- Deputy Director - Information

Basic Function:

Overall responsibility for spreading the message of preventive health to the people of the state through different platforms. Use all such opportunities wherein which the message of Public Health can be spread.

Duties, Responsibilities and Authorities:

- Monitor all matters relating to information, education and communication related to Health of the people of Karnataka.
- Responsible for procurement, distribution and utilisation of educational materials related to RCH and Maternal and Child Health
- Incharge of the publication of KUTUMBA, every fortnight
- Conduct the field verification of RCH acceptors and incentives paid to the RCH beneficiaries.
- Coordinate with State Institute of Health and RCH in formulating the content of the course about Public / Preventive Health and its allied areas
- *Post programme evaluation and its impact on the public (quantifiable)*
- Conduct in-service training to the RCH staff on I.E.C. activities.
- *Head the department press and its activities*
- *Coordinate with different Medical and health departments in the contents related to the publication and distribution*
- *Spread the message of drug addiction / alcohol and educate people for being away from smoking, drinking and other forms of drug addiction.*

Main Accountabilities:

Error free distribution IEC material and other publications from the department

Training Areas:

a)Mass communication b)Conducting exhibitions c)Multi-media

Job Title: **DEPUTY DIRECTOR – INFORMATION**

Reports To: **Joint Director (Information, Education & Communication)**

Immediate Level Subordinates:

- Field Publicity Officer

Basic Function:

Ensure the spread of the error free desired information among the public of the state, organise exhibitions at small/big congregations to bring awareness in the areas related to Health. Liaison with other agencies in production of films related to educational aspects of health

Duties, Responsibilities and Authorities:

- Responsible for entire Mass Media and Mass education programmes of Family Planning in the state.
- Co-ordinate the family planning mass education programme in the state, districts with the help of all other states and Government of India Publicity units.
- Plan and design for production and distribution of publicity material for Mass education, and extension education in the state.
- Collect information on all districts about the newspapers in circulation, cinema theatres in operation, audio-visual units of State and Government of India available and other mass media education items, so as to use them effectively for education.
- Liaison with the press, radio, field publicity units and mass media to provide necessary background material to them.
- Guide and supervise the work of District Mass Education and Information officers and District Health educators.
- Bring out success stories of individuals adopting family planning methods by visiting services, camps, wherever held in the districts.
- Prepare digests of critical newspaper comments and bring such comments to the notice of the administrative head of the department and technical officers of the State Family planning Bureau and also arrange for issue of any clarification to remove the mis-apprehension or doubts in the minds of the people.
- Plan for the production of sufficient printing matters for running the offset press.
- To stimulate and coordinate the effective use of all types of educational material by all categories of Family Planning field workers as well as others.
- Monitor the out door publicity programmes.

Training Areas:

- Conducting exhibitions
- Effectiveness of theatre arts
- Multi-media
- Effective use of print media
- An internship with DAVP, GOI

Job Title: **FIELD PUBLICITY OFFICERS**

Reporting To: **Deputy Director – Information**

Immediate Level Subordinates:

- Programme Assistant
- Health Education Officer

Basic Function:

Incharge of all the publicity material procured by the IEC functionary of the Directorate of Health Services. Plan and implement the ways to take the message even to the rural areas in the state.

Duties, Responsibilities and Authorities:

- Encourage production of family planning films in the state with the help of available official and or private agencies.
- Arrange production and distribution of family planning filmstrip, slides, recordings and distribution thereof.
- Supervise the functioning of audio-visual units in the districts.
- Maintain effective liaison with the media units
- Assist in the organisation of Family Planning campaign at the State/District level
- Initiate and supervise design and fabrication of all exhibits for the exhibition
- Direct and supervise the activities of Exhibition in the Districts/Rural centres
- Guide and help the district MEIO's Extension Educators
- Supervise effective use of display publicity, hoardings, bus-boards, wall paints and metallic tablets etc. in the state
- Such other allied duties as may be assigned by the AD (RCH)

Main Accountabilities:

- Number of exhibitions conducted

Training Areas:

- Conducting exhibitions
- Communication in mass media

Job Title: **HEALTH EDUCATION OFFICER**

Reporting To: **Field Publicity Officer (Functionally)**
District Health Officer (Administratively)

Immediate Level Subordinates:

Basic Function:
Primary responsibility to establish working relationship with NGOs and local bodies in spreading the message of Health, taking stock of the available material and plan for procurement and distribution of the same.

Duties, Responsibilities and Authorities:

- Develop and maintain a close working relationship with the State Health Education Bureau in order to utilise fully the technical and physical resources of the bureau for the family planning programme.
- Develop and maintain close working relationship with different agencies that can contribute to the educational programme like the education department, information department, All India Radio, Development and Panchayat Raj Department etc. and utilise their resources.
- Promote the educational activities of the voluntary agencies and local bodies
- Co-ordinate the efforts of honorary, education leaders and assist them in their work.
- Assess the educational needs and recommend educational programmes for district and state Training institutes.
- Responsible for planning and operating a statewide information programme utilising all available channels and media of mass communication.
- Provide technical guidance to the District Family Planning Bureau.
- Assess the needs of educational material and equipment and arrange for their procurement and distribution.
- Assist the AD - RCH in assessing training needs in health education and develop a plan for detaining personnel for training.
- Organise seminars, workshops, conferences and periodical staff meetings.
- Attend to such other functions as may be assigned from time to time.

Training Areas:

- Conducting health campaigns
- Conducting exhibitions
- Effective use of theatre arts

Job Title: **PROGRAMME ASSISTANT**

Reporting To: **Field Publicity Officer**

Immediate Level Subordinates:

Basic Function:

Duties, Responsibilities and Authorities:

- Assist Field Publicity Officer in compiling organising and production of field programmes, exhibitions songs and drama programmes, traditional media programme and other cultural activities to communicate Family planning programme to the people.
- Assess the programmes sponsored and consolidate them.
- Assist in selection of artists and types of programmes which the audience prefer.
- Assist in selection of movie films on Family planning, exhibits for exhibition purposes, production of family planning films to be produced by State Family Planning Bureau.

Job Title: **DEPUTY DIRECTOR – SCHOOL HEALTH**

Reporting To: **Joint Director – Health Promotion**

Immediate Level Subordinates:

Basic Function:

Spread the message of good health among school children and arrange to conduct periodic health check-ups to school children. Also monitor the hygienic conditions around the schools and suggest corrective actions to the municipality authorities and heads of respective schools/institutions

Duties, Responsibilities and Authorities:

- Coordinate with the District Education Officers and organise for periodical health check-up for the students in different schools
- Coordinate with District Health Officers in spreading the message of Public Health among the students of different schools in the state
- Ensure proper hygenic conditions around the premises of schools in the state and suggest corrective actions to the heads of institutions
- Encourage literary activities among the students of different schools
- Spread the message of special days (world health day, AIDS day, day for the physically handicapped, etc) among the students of different schools and educate the pupils about them.
- Send reports to the MIS functionary for any interpretation regarding the health of school going children in the state.

Main Accountabilities:

Number of school health programmes
Evaluation of the programme

Job Title: **ADDITIONAL DIRECTOR – PRIMARY HEALTH**

Reporting To: **Director – Public Health**

Immediate Level Subordinates:

- Joint Director – Primary Health

Basic Function:

Effective Implementation of all national and state public health programmes. Preparation of a primary health care policy for the State. Overall responsibility for establishing, managing and development of health infrastructure at the primary level in the state. Is responsible for the public health services delivered at the primary level in the state. Monitor and evaluate the basic programs at all the Primary Health Centres in the state, availability of basic infrastructure facilities offered to all the Primary health centres and effective patient care at PHCs. Also monitor the referral system .

Duties, Responsibilities and Authorities:

- Ensure that quality public health care services are available to the target population
- Ensure that the primary health centers and referral hospitals are easily accessible to the population, review need for rationalisation and relocation of some health units as well as setting up new health units in order to improve accessibility and service coverage.
- Review and evaluate the existing policies and procedures and work methods by means of periodic and special studies
- Review the MIS reports generated and take corrective actions
- Review and recommend the upgradation of primary health infrastructure in the state
- Work out improved methods and procedures to achieve the objectives and Develop standards, methods and measurements of the PHC activities
- Monitor the utilisation of public health resources throughout the state and adopt means of bringing optimum utilisation
- Coordinatr periodic health promotion activities that are carried out in the community
- Visit all districts esp PHC's at random and review the Public health programmes in the state, atleast once a year
- Ensure that medical audit and internal audit has been carried out in as many PHC's as possible at periodic intervals
- Submit all relevant material which can be hosted on the department website
- Ensure that full economy and expenditure control is observed in all public health related operations and activities in the state at the PHC's level.
- Ensure that full complement staff are available at all the PHC's
- Monitor the training needs identification of the PHC personnel in the department and nominate for the respective programmes to be conducted by State Institute of Health and Family Welfare or other institutes from time to time

- Monitor effective implementation of various public health programme
- Coordinate with AD-planning on the budgeting activities

Main Accountabilities:

- Visit all districts and taluks which conduct the national/state public Health programmes in the state atleast once in a year

  Address all PHC officers in the districts atleast once in a year and appraise them of the expectations of the government and their deliverables

- Ensure quality of care in all PHC's through periodic medical audit and patient satisfaction surveys
- Achievement of Health goals of state
- Ensure optimum capacity utilisation of hospital infrastructure through periodic review of MIS reports (hospital efficiency indicators) of all hospitals
- Increase of health infrastructure (need / technology based) in the state in coordination with planning cell

Training Areas:

- Attend Management Development Programmes at international institutes such as Harvard, John Hopkins, etc in areas of Public Health Policies, health policies, New business models in Health care.
- Study Health care facilities and delivery system in both developed and developing countries and also attend national and international and to share the experiences of Karnataka and get a feedback.

- Awareness of different kinds of Public Health Programmes in the developed and developing countries
- Project execution methodology of international agencies
- Health Management

Job Title: **ADDITIONAL DIRECTOR - CMD**

Reporting To: **Director – Public Health**

Immediate Level Subordinates:

- Joint Director – Vector Borne
- Joint Director – Leprosy
- Joint Director – TB
- Joint Director – Vaccine
- Joint Director – Lab

Basic Function:

Nodal Officer for the State Surveillance unit. Ensure proper implementation of various national and state programmes related to Leprosy, Vector borne diseases and TB. Ensure proper maintenance of laboratories in the state.

Duties, Responsibilities and Authorities:

- Evolve strategies for Surveillance
- Set up procedures for collection, analysis and reporting of morbidity and mortality data.
- Monitor the functioning of the District Surveillance Units
- Co-ordinate with other related Departments at the State level, Indian Medical Association, Programme Officers, Voluntary Organisations, etc.
- Conduct surveys, compile morbidity and mortality data, by disease, for planning and working out priorities and strategies.
- Evaluate the effectiveness of interventions instituted to control epidemics.
- Carry out research studies and suggest innovative and the effective methods of intervention
- Act as the nodal Surveillance unit at the district level and provide the missing link between the primary and secondary level sub-systems
- Provide early warning of outbreak of epidemics of all the major communicable diseases through continuos Zilla Panchayat, PWD, Fisheries, Irrigation, Agriculture, Rural Development, Indian Medical Association, Programme Officers, Voluntary Organisations, etc.
- Planning, implementation, reviewing and monitoring of communicable diseases such as Diarroheal diseases, Kyasnoor Forest Disease, Guinea Worm etc.
- Monitor the running of Diagnostic Laboratory, Shimoga, Vaccine Institute, Belgaum, communicable diseases investigation and Training Centre, Mandya.

- Monitor all activities relating to manufacture (at Vaccine Institute), supply and distribution of vaccines
- Monitor the precautionary measures and preparedness of state machinery in tackling with any natural calamities
- All matters relating to Air, Water and Environmental pollution, and Slum Clearance board
- Monitor the National Leprosy Eradication programme implementation throughout the state
- Monitor the overall performance of National TB Control Programme and Lady Wellington TB Demonstration & Training Centre, Bangalore
- Work in coordination with the office of Additional Director - Urban Health in control of Malaria & Filaria and such other diseases.

Main Accountabilities:

- Conduct surveys, compile morbidity and mortality data, by disease, for planning and working out priorities and strategies.
- Evaluate the effectiveness of interventions instituted to control epidemics.
- Carry out research studies and suggest innovative and the effective methods of intervention
- Set up procedures for collection, analysis and reporting of morbidity and mortality data.
- Monitor the functioning of the District Surveillance Units
- Co-ordinate with other related Departments at the State level, Indian Medical Association, Programme Officers, Voluntary Organisations, etc.

Training Areas:

Health management

Epidemiological methodology

Programm management

Job Title: **JOINT DIRECTOR - VECTOR BORNE**

Reporting To: **Additional Director – CMD**

Immediate Level Subordinates:

- District Malaria Officer
- District Filaria officer
- District Health Officer

Basic Function:

Ensure proper planning and implementation of national and state programmes related to all Vector Borne diseases and proper utilisation of funds allotted for each unit/district. Liaison with the municipal authorities in ensuring hygenic living conditions for the people in the state and appraise them of better methods of sanitation and the importance of that.

Duties, Responsibilities and Authorities:

- Planning, implementation, reviewing and monitoring of communicable diseases such as Diarroheal diseases, Kyasnoor Forest Disease, Guinea Worm etc.
- Planning, implementation, monitoring of all matters connected with the Ecology, Malaria, Filaria and other mosquito borne diseases.
- Process the reports generated through to Central Malaria Laboratory and take preventive measures to curb the spread of the disease.
- Planning the activities like budget allocation and key sustenance factors related to various Diagnostic Laboratory, Shimoga, Vaccine Institute, Belgaum, Communicable Diseases Investigation and Training Centre, Mandya.
- All matters relating to manufacture, supply and distribution of vaccines
- Work in coordination with various civic bodies relating to natural calamities.
- All matters relating to Air, Water and Environmental pollution, and Slum Clearance board
- Overall incharge of curing and arresting the spread of Malaria & Filarial diseases in the state
- Work in coordination with the office of Additional Director - Urban Health in control of Malaria & Filaria and such other diseases.

Main Accountabilities:

- Planning, implementation, reviewing and monitoring of communicable diseases such as Diarroheal diseases, Kyasnoor Forest Disease, Guinea Worm etc.
- Planning, implementation, monitoring of all matters connected with the Ecology, Malaria, Filaria and other mosquito borne diseases.
- Process the reports generated through to Central Malaria Laboratory and take preventive measures to curb the spread of the disease.

Training Areas:

Health management

Epidemiological methodology

Programm management

Job Title: **JOINT DIRECTOR - TB**

Reporting To: **Additional Director – CMD**

Immediate Level Subordinates:

- District Health Officer
- District TB and AIDS Programme Officers

Basic Function:

Carry forward the different national and state programs related to Tuberculosis and AIDS in the state, treatment of the respective patients and monitor the processes of control of TB

Duties, Responsibilities and Authorities:

- Monitor different national and state programs related to Tuberculosis and AIDS in the state
- Coordinate with the office of AD – IEC for any material or inputs for the publicity material to educate the people in the areas of TB and AIDS
- Monitor the process of treatment for some chronic TB patients in the state
- Coordinate with AIDS Society in the state to educate the people regarding the precautions to be taken about AIDS

Main Accountabilities:

- Monitor different national and state programs related to Tuberculosis and AIDS in the state

Training Areas:

Health management

Epidemiological methodology

Programm management

Job Title: **JOINT DIRECTOR, VACCINE INSTITUTE, BELGAUM**

Reporting To: **Additional Director – CMD**

Immediate Level Subordinates:

- Deputy Director – Epidemiological surveillance Unit
- DHO
- Deputy Director - Pharma

Basic Function:

Manufacture ARV vaccine and its distribution to the institutions of the State and ensure proper procurement, storage and distribution of UIP / Vaccines in the districts of Gulbarga and Belgaum divisions

Duties, Responsibilities and Authorities:

- Manufacture of ARV vaccine and its distribution to the institutions of the State.
- Coordinate with all NGO's and department agencies
- All matters relating to the UIP/ Vaccines, procurement, storage and distribution to the districts of Gulbarga and Belgaum divisions.

Training Areas:

Health management

Epidemiological methodology

Programm management

Job Title: **JOINT DIRECTOR - LABORATORIES**

Reporting To: **Additional Director – CMD**

Immediate Level Subordinates:

- Deputy Director – Viral Diagnostic Lab, Shimoga
- Deputy Director – Bacteriological lab, PHI, Bangalore
- Chemical Examiner
- Chief Chemist

Duties, Responsibilities and Authorities:

- Planning, implementation, monitoring and reviewing of various activities of Public Health Laboratories in the State including district Laboratories, Divisional laboratories, Divisional Food Laboratories and laboratories at various levels
- Implement Food Adulteration Act procedures in coordination with the municipal and corporate functionaries at different locations in the state.

Non-Conformance to Transfer Orders

5.15 Transfer orders are not necessarily followed by the personnel. The personnel is given a choice to refuse transfer in lieu of losing his promotion. However it has indicated that personnel use references to get transfers of their choice. This leads to non-favored locations not being posted for long duration of time.

5.16 It has been suggested by a cross section of personnel that specific measures need to be undertaken to control in-discipline regarding transfer orders. These measures include :

- Recording use of any reference for transfer of choice, in the service book, which will be reflected in the future career growth of the personnel
- Delay in PG admission etc

Consideration of Pending Service Period

5.17 The current policy of minimum period at a post is in the range of 6-7 years leading to a personnel to have at least 17 years of experience prior to the post of Deputy Director. This policy has led to various personnel being promoted (especially at senior levels such as JD, AD etc) having around 6 months to one year of pending service period. The roles of the senior posts being mainly in the form of strategy and planning, this period is not sufficient for effective implementation of plans.

5.18 Considering the importance of prior field experience for the directorate posts, it is recommended that the promotion policy in terms of minimum period of service be re-looked to facilitate Senior Personnel being promoted to a post having at least two years of pending service. Alternatively, the personnel can be given the option of in-service promotion with requisite compensation benefits whereby he will continue to remain in his previous post.

Qualifications and Training

5.19 This section covers observations and suggestions on matters relating to qualification of personnel and the need for training.

Qualification Related

5.20 The qualification related matters discussed in the ensuing paragraphs are primarily of :

- Post-Specific Qualifications
- PG Course Selection

Post-Specific Qualification

5.21 The proposed structure pre-requisites the need for post – specific qualifications for the various personnel manning these posts. The division of the department into

Public Health and Medical wings necessitates the need for respective qualification. Further, for the function based posts such as JD (Optha) under the medical wing, specific specialization e.g. MD /MS (Optha) will need to be mandatory.

PG Course Selection

5.22 The medical personnel of the DHFW are provided sponsorship for post graduate qualification after completion of three years of service. They are selected into the course on the basis of their seniority. The key concerns brought to our notice were :

- Postgraduate subject selection is driven by the candidate preference instead of the DHFW requirements leading to mismatch of specialists' vis-à-vis state needs.
- Certain percentage of candidates do not complete the course in the specified duration leading to on one hand blocking of seat of a more deserving candidate and on the other under-utilization of DHFW expenditure.

5.23 In order to maximize the benefits of postgraduate course sponsorship, it is suggested that the DHFW consider a merit based selection into the programme as compared to a seniority based selection. The proposed selection procedure can incorporate the following standards,

- Introduction of PG course selection examination similar to that held for the non-government students. However, it must be noted that the seats reserved for the government students will still remain the same.
- The merit selection should also incorporate field and academic experience including the performance evaluation conducted through the Confidential Report (CR) procedure.
- The subject selection should be on the basis of expected vacancies under each specialization in the DHFW. Candidates to be permitted to indicate preference, however admissions to PG programme to be done through the counseling process. Further, on non-acceptance by the candidate of the subject offered, the candidate will lose his chance of DHFW sponsorship unless he re-visits the selection procedure in any future period. Can opt for only one clinical speciality with option for Management training if required.

5.24 In addition the DHFW may consider charging the candidates an appropriate penal fine (in lieu of expenditure incurred by the DHFW) on non-completion of course in the specified period due to in-discipline or failure in the examinations.

Training

5.25 Management / Administration training and induction programme for new entrants into the department is currently not a thrust area in the DHFW leading to lack of motivation and uncertainty of the various procedural issues. The average personnel has limited / poor programme management abilities of national health programs especially

that of public health and also poor administrative management of hospitals. This has been observed across all categories of staff.

5.26 As discussed in the previous chapter, specific thrust for training of DHFW personnel is one of the key features in the proposed organisation structure. It is recommended that the training emphasis may begin with the following initiatives :

- Administration training to be provided to all personnel holding administrative posts such as head of PHC, TPHO,DPHO,TMO,DMO etc
- Short-term and extensive training programs to be conducted for awareness of all national health programs
- Clinical training in areas of specialization / job role requirements for familiarizing with latest technology and clinical skills
- The minimal knowledge of public health amongst the staff requisites training in public health to be at least of 6 – 10 weeks duration.

A beginning in this direction has been made by KHSDP but these programmes need to be thoroughly evaluated and renewed.

Private Practice

5.27 The private practice being conducted by the staff after duty hours is a routine matter for most of the doctor personnel of the DHFW. This issue has been much debated upon and a decision is yet to be arrived at on the same. Some of the suggestions given by members – Task Force on Health is given below :

- Though private practice is banned, certain medical personnel carry on private practice to the detriment of their official responsibilities
- Factors affecting decision on permitting private practice are :
  - Need to ensure availability of medical services at all hours
  - Essentiality of such services at the local level specifically in rural areas
- Recommendations on private practice :
  - MOs at the PHC level to be given rural allowances in lieu of private practice
  - Specify duty hours, publicly announce them and attendance during these hours to be strictly followed and monitored by the community
  - Ban private practice at all levels
  - Prohibition of association of doctors as consultants to private nursing homes
  - Public health cadre and Administrative Officers to be given special allowances

5.28 Few of the reasons offered by the various doctors on the private practice is that the non-practicing allowance offered as part of compensation is in no way close to what the doctor would earn in private practice. Banning private practice at senior levels without adequate compensation, would result in movement of highly skilled practitioners to private service. An appropriate mechanism should be designed by the DHFW whereby public service and doctor motivation will be at the acceptable level.

5.29 While private practice after duty hours may seem acceptable taking into consideration factors outlined above, it has been observed that private practice is conducted even during duty hours. This may be in the form of accepting consultation fees from the patients visiting the DHFW's health centres or conducting external private practice during official duty hours

5.30 Control measures need to be adopted by the DHFW with regard to private practice, especially during duty hours through stringent disciplinary actions.

Adherence to Working Hours

5.31 The working hours for the different health centres are given below :

- PHC/CHC/Taluka
  - 8.00 a.m. to 12.00 p.m.
  - 2.00 p.m. to 5.00 p.m.
  - At Taluk level Duty Doctor has night shift of 5.00 pm to 8.00 am
- District Hospital
  - 9.00 a.m. to 1.00 p.m.
  - 2.00 p.m. to 5.00 p.m.
- Directorate
  - 10.00 a.m. to 5.30 p.m. (General Shift)
  - Lunch break: 1.30 p.m. to 2.00 p.m.

5.32 It has been brought to our notice that as certain medical staff do not stay in the quarters, they may not be available during emergencies. Moreover, in health centres situated around urban centres, the working hours are not necessarily adhered to as the staff spend a lot of time on travelling to work.

6. Re-alignment of Staffing Pattern

6.1 The study of review of organisation structure involved identifying any concerns addressed by personnel on the staffing pattern and any re-alignment of the same arising out of the proposed organisation structure. A detailed study is being conducted by CESCON wherein the terms of reference are to determine Manpower Planning requirements .

6.2 As the above study is a detailed manpower planning exercise, it was suggested to us that we limit the staffing pattern to the top management structure.

Observations

6.3 Key concerns addressed by various personnel on the staffing pattern are given in the ensuing paragraphs.

Manpower shortage

6.4 Sanctioned manpower is defined for each section/function within the department. However, it has been brought to our notice that in most departments, quite a few of the sanctioned posts are vacant. These could be due to various reasons such as transfer posts not taken up by the personnel etc.,

Shortage of Staff Nurses

6.5 There is an indicated shortage of staff nurses at the District Hospital visited. Nurses forming a critical part of para-medical staff, shortage of the same will lead to lesser assistance to medical staff in their functioning.

Shortage of ANM (Female Health Assistant)

6.6 The training for future batches for the ANM post has been stopped leading to an expected shortage of ANMs at a later point of time.

Mismatch of requirements vis-à-vis personnel

6.7 As covered in the previous chapters, the staff assigned to various health centres do not necessarily meet the professional/specialization requirements at these centres. There is a need to implement facilities based posting.

Unequal distribution of Staff

6.8 It has been observed that there is an unequal distribution of staff especially in the group D category across the health centres. It has been observed that contracting out services for non-clinical work of hospital, especially hospital hygiene and cleanliness has been successful under KHSDP. This will definitely reduce the burden of the state of maintaining these hospitals through Group D.

6.9 Further, as indicated earlier, in a single hospital there are 3 ENT specialists while none at another.

Skewed utilization of staff

6.10 The current utilization of staff is found to be skewed or under-utilized. E.g.

Over utilization of Female Health Assistant

Under utilization of Male Health Assistant

Lab assistants posted at PHC, etc without requisite material to conduct their work

Non-availability of Allocated Staff

6.11 In certain situations, the allocated staff for a department is assigned other duties leading to non-availability of the staff for the concerned department's activities. E.g. In the HET cell, certain staff are utilized by the CAO as a result of which HET activities are under staffed.

Proposed Senior level Staffing Pattern

6.12 On the basis of the proposed organisation structure, the Senior Level Staffing pattern is given below :

- DGHS/Commissioner : 1 no.
- Director : 4 nos
- Additional Directors : 10
- Joint Directors : 20

7. Need of Procedure Review

7.1 As a part of the organisation structure review, detailed discussions were held with a cross section of personnel across various categories of health centres (PHC, CHC etc) covering both rural and urban areas and the directorate. From these discussions, certain areas where identified wherein there is a need to conduct a detailed procedure review for improving the functioning of the department. The key areas identified are :

- Planning and Budgeting
- Drug Procurement and Disbursal process
- Register/Record maintenance
- Management Information Systems

Planning and Budgeting

7.2 Planning for the various national and state level health programs and their distribution across the entire network of the DHFW is one of the key activities of the DHFW. Planning and budgeting are critical to the overall success of implementation due to the vastness and complexity of these programs. However, it has been observed that the planning and budgeting exercise is conducted in a mundane manner as highlighted below :

- There is no scientific need based process e.g. Epidemiological basis, morbidity pattern etc., utilized for planning and budgeting
- The budgeting exercise is conducted in the form of re-allotment of figures based on expenditure pattern
- Further, budgeting for programs are ad-hoc with no consultation from program officers. More often, the budgeting is seen as a directive from a department rather than a consultative form.

7.3 As reiterated in the previous paragraphs, planning and budgeting being critical functions, for efficient implementation of various programs a scientific based approach to planning needs to be considered. Thereby, it is imperative that a detailed study be conducted to suggest an effective planning and budgeting mechanisms and procedures.

Drug Procurement and Distribution

7.4 Drugs at the health centres of DHFW are received from the following sources :

- DHO : 60 %
- GMS : 40 %

7.5 The various concerns raised by the DHFW personnel with regard to Drug procurement and Disbursal are :

- Planning and processing of drugs are not need based leading to shortage of certain supplies in case of emergencies
- Though funds are provided for ASV for procurement of emergency drugs, these funds are unavailable for utilization
- Complaints have been received regarding high pilferage of drugs through the entire supply chain i.e. from the GMS store to the PHC via the DHS
- Delays in supply or non-supply of essential drugs have led to the various centres to claim the cost from the patients. Normally the drugs received on the annual quota are sufficient only for one month. This in effect defeats the very objective of Public Care.

7.6 A detailed procedure review on the drug procurement and disbursal cycle will determine the gaps in the process that subsequently lead to delay in receipt of supplies. The procedure review will also provide recommendations on internal control policies and procedures.

Register / Record Maintenance

7.7 Detailed registers have been prescribed for recording implementation details of the National Health Programmes. However, it has been observed that there exists a certain delay in register updation and information flow. More often there is a short supply of registers especially at the PHCs leading to the ANMs procuring them at their cost. Though the cost incurred is subsequently reimbursable, the entire procedure causes delay and inconvenience to the ANMs.

Management Information Systems (MIS)

7.8 The MIS exists to the extent of collating information from all sub-ordinate levels and the submission of the same to the superior. Currently, no analysis is conducted on the data available, at any level in the DHFW with the exception of the senior-most levels. It has been observed that even at the DJD and JD levels, the role of the personnel is restricted to collation of data.

7.9 Strategic planning being a thrust area for decisions on National Health Programs, it is imperative to have an effective MIS system that will provide information support for decision making. There is thus a need to conduct a detailed process review to determine information needs at each level.

8. Recommendations & Conclusion

8.1 This section provides a summary of the issues discussed about in the previous chapters. The recommendations are provided keeping in view the following points:

- Increase the efforts on preventive and promotive health
- Increase the promotional avenues for the personnel (preferably doctors) in the department and thus increase their morale
- Making the personnel accountable for the success of the department by enlisting the key accountability areas
- Better implementation of the projects planned and in the future
- More thrust for training the personnel and thus equip them with contemporary technical and managerial skills

8.2 The recommendations (possible solutions) for the above issues are devised after thorough discussions with the members of task force, office bearers of the Karnataka Medical Officers Association, doctors in the department and others, directly involved in the department. The key recommendations and conclusions about the reorganization of the Department of Health & Family Welfare are enlisted below:

Top *structure*:

8.3 **Commissioner/Director General of Health Services (DGHS):** He reports to the Principal Secretary. Three options were considered with relation to this position in the department: they are:

- Continue the occupancy of a senior IAS officer in this position for the present till an alternative is achieved.
- Place a doctor who rises from the ranks in the department and has the functional knowledge of Public Health and Medical along with good project management and administrative management skills. Then, this post may be renamed as Director General of Health Services. Until a person with utmost caliber within the department is identified, an IAS functionary may only continue as Commissioner, Directorate of Health Services. But once a DGHS is instituted, it must be the regular exercise of the government to groom his/her successor to occupy the senior most position next. The continual change from DGHS to the IAS officer may only effect the morale of the department people and thus the functioning of the department.
- Create a contractual position at the top who can be called the Chief Executive (Health) and specify the qualifications background and experience for the person. He should have extraordinary leadership abilities, managerial capabilities, capacity for strategic thinking and planning, skills for change management and enhanced communication. The key result accountability areas can be specified. The profile of the person to occupy this position

should really be of greatest standards since the operations include mammoth size and the acceptability of the person from outside the system is also difficult.

- Creation of an advisory board consisting of eminent health and administrative professionals who will be the monitoring and evaluation body for the department and also advice on strategic planning with future perspectives for the department. The DGHS will report to this advisory Board at regular intervals.

Directorate structure:

8.4 The activities of the directorate are basically divided into two streams of Medical and Public Health.

8.5 **Medical** functionary looks after the hospital administration in the state, which includes even the Non Communicable Diseases. All the specialist cadre personnel report to the head of this functionary (Director – Medical)

8.6 **Public Health** functionary looks after the preventive and promotive health of the people of the state. This includes the Primary Health Centres, the RCH Communicable Diseases, the IEC and the Urban Health components.

8.7 It was thought to give more emphasis to the programs and other activities in the N. Karnataka region for all the existing state of affairs of health in that region. A set of seven districts are identified in that region to give more emphasis on and a position has been proposed (Additional Director) to coordinate and monitor the activities in that region.

8.8 Emphasis was also proposed to be given to the present nascent area of future planning and research activities. An Additional Director post is proposed to head the functions of Planning, Research and MIS activities

8.9 It was observed that there was lack of coordination between different External Aided Projects and different functionaries in the department. For this reason, it is being proposed to introduce a directoral level person to head and monitor all the External Aided Projects in the state (Director – EAP).

8.10 For better coordination between the numerous NGOs working hand-in-hand with various functionaries of Department of Health and Family Welfare, a special cell for NGO participation and coordination is proposed to be head by a directoral level person (Director – NGO participation).

8.11 It is also proposed that a special wing be created to form the procurement and maintenance cell to manage the activities of equipment, machinery and civil works of the department.

8.12 The DHO and DMO should carry out monitoring visits regularly on a continous basis with a check list and enforce disciplinary action wherever required.

8.13 More financial and functional autonomy be given to programme officers so that they are also responsible for the programme as much as the DHO / DMO.

8.14 Create leave reserve Doctors posted at the District HQ to replace staff posted for training or on long leave.

State Institute of Family Welfare and Training (SIHFW):

8.15 This Institute founded under the project IPP – IX for training the required personnel in the department is proposed to play a larger role in their development. Keeping in view the dynamic nature of the circumstances the personnel of the department are required to work and the pace of decision making, it is proposed to have an autonomous institute as SIHFW.

8.16 The new organization set-up of SIHFW will be head by Director who reports functionally to Principal Secretary – Health will be assisted by:

- JD
- DD
- District Training Officer
- Other training personnel involved in training in Health & Family Welfare throughout the state

8.17 It is proposed that hitherto training function of Health Education and Training (HET) functionary of the Department be shifted to SIHFW. All the personnel involved in training would be a functionary of SIHFW.

8.18 It is proposed that all the functionary heads in the department and the office of AD – Planning submit the training areas required for the personnel working in their section to SIHFW. SIHFW in turn prepares the modules of training to be conducted for different personnel in the department. The structure of SIHFW may be designed such that the following processes can be handled smoothly:

- Receive requisition for training areas from different functional and sectional heads (efforts should be made towards self-appraisal of the people in the department and the areas identified during that process too can be forwarded to SIHFW). Most of the times, clarifications are sought from the reporting authority about the training area specified. The individuals may also be counseled to fill any gaps during the training need identification process within each functionary. Directions should also be taken from the office of DD - Training, reporting to JD – Planning since he is responsible to identify the process of linking the organization's long-term and short-term goals to the individuals development, identify career planning processes for the department people, recommend the format and module for orientation programme for new-recruits and any refresher courses for doctors and others from time to time.

- Analyse the inputs from different sources and cluster them so as to offer the programme in easy modules at different places easily
- Train the internal training staff (TOT) to enable them to conduct programs more effectively
- Prepare the external trainers' list and their competencies in different areas related to Health Management, Hospital management, programme management, logistics management, etc.
- Inform the respective persons and their respective reporting authority about the training programme identified for them and the planned period (including the dates). This should happen to enable the proposed trainee and the relieving authority to plan better so that the general public is not at loss any time
- Coordinate the training programme at the place determined. Other administrative matters like providing the accommodation for outstation candidates, providing good facilities if a residential programme is planned, etc should also be taken care of.
- Inform the trainers about the expectations from them should also be done much prior to the programme.
- Have a feedback mechanism on the quality of inputs provided, for effective monitoring and plan for any improvements.

8.19 Apart from the above, the new organization set-up should also take care of three tier training system for better reach to the people in the department. This includes:

- State level
- Regional level
- District level

8.20 The district level system should reach to the taluka level and the PHC level, including the doctors, nurses, pharmacists, health workers and the ANMs.

8.21 **The changing systems impel the SIHFW to conduct courses in the areas of Medical audit and Internal audit too apart from other courses. These areas provide inputs in the accountability of the people in the system and thus its sustenance.**

8.22 The financial sustenance of the department can be derived by different means:

- Allot specific budget for this autonomous institution depending on the number of training programs to be conducted and the number of people to be covered in the department, the number of trainers required, the infrastructure to be acquired, etc

- Training fees can be charged for the training programs even for the Department of Health and Family Welfare, Government of Karnataka and raise the bill for each programme planned/announced/concluded

- Open the facilities of SIHFW for other institutions as well to train their personnel as well

8.23 Whatever maybe the structure and status of SIHFW, more coordination is envisaged from different sections/functionaries in the department for effective utilization of its resources and realize its basic purpose of existence as a single nodal agency for training.

8.24 The morale of the department needs to be uplifted through impartial promotions postings, transfers, selection for PG Courses incentives etd. As mentioned earlier the SIHFW should be the nodal training centre in capacity building of the health personnel at all levels.

GOVERNMENT OF KARNATAKA

TASK FORCE ON HEALTH AND FAMILY WELFARE

A Commissioned Research Study

REVIEW OF ORGANISATION STRUCTURE AND DESIGN OF JOB RESPONSIBILITIES FOR HEALTH AND FAMILY WELFARE DEPARTMENT

VOLUME - II

By

A. F. FERGUSON & CO
MANAGEMENT CONSULTANT DIVISION
Bangalore.

Introduction

The following pages form the Volume II of the organization restructuring study report. This volume contains the job descriptions of the unique and identified positions at the Directorate and different hospitals and other offices of Department of Health & RCH, Government of Karnataka.

Methodology

- Collating information available in different documents about the basic functions and the responsibilities and duties of different personnel in the department
- Discussions with different functionaries in the department about their basic functions and duties along with any modifications required in the existing set-up to meet any future requirements.
- The salient features of the proposed structure are also discussed with people at different functions and representatives of Medial Officers Association and certain key functions were evolved
- The gaps in the existing manuals and other departmental orders were identified and utmost care is taken to address them.

Terminology: Job description for each identified position was explained under different headings. They are:

Job Title:

The position / designation for which the job description relates to.

Reporting to:

This position for which a person is responsible to and it is at most of the occasions, the appraiser of the person handling the above referred position / designation. At certain instances, dual and multi relationship was reported. To have better monitoring of the envisaged procedures and policies, these were imminent. Also to have functional inputs and proper care to follow the authority schedules, dual reporting was envisaged.

Immediate Level Subordinates:

This explains the reach of work of the incumbent and the basic logic of division of work among the subordinates. However, only the medical profession designations are only given as part of the subordinates' list. This doesn't include the staff reporting at the office of the incumbent

Basic Function:

This explains in brief the function of the person handling the position and the relationship with other functionaries in the department.

Duties, Responsibilities and Authorities:

These are the expected deliverables and the guidelines for the incumbent in performing to the expectation of his/her senior (superior). These form the basis in his one's approach in taking up a job or division of work in the department. The responsibilities are split among the functionaries in the department, with the overall responsibility lying with the head of the department.

The Financial, administrative and disciplinary powers are enclosed as annexures and these are as per the KSCR rules and regulations.

This list may just guide the head of department in dividing the work (delegating the work) among his subordinates.

Main accountabilities/Key Result Areas/Performance Areas:

These are the reference points for the performance evaluation of the incumbent. The duties, responsibilities and authority were considered to decide the accountabilities

Training Areas:

With reference to the duties and job responsibilities of the incumbent, and to raise to the expectations of the concerned authorities and people at large, a set of generic areas for training and possible methods of training for overall development of the incumbent. This does not refer to any training needs assessment done but the essential skill set of the incumbent.

Disclaimer: proformas submitted thro ugh the DHS to all personnel – have still not been received but however we have still compiled the job descriptions based on discussions with the senior staff of the Directorate .A limited number of job descriptions are presently available with the department.

Job Title: **COMMISSIONER/DIRECTOR GENERAL OF HEALTH SERVICES**

Reporting To: **Principal Secretary – Health & Family Welfare Government of Karnataka**

Immediate Level Subordinates:

- Director – Medical
- Director – Public Health
- Director – External Aided Projects
- Director – Procurement & Maintenance
- Additional Director – Planning
- Additional Director – N.Karnataka
- CAO – Finance
- CAO – Vigilance

Basic Function:

Responsible for effective functioning of the Health Systems in the state to deliver quality health care. Responsible for integrating the entire Medical health function throughout the state and provide appropriate professional leadership for continual improvement and upgradation of medical health services in the state including Hospitals, health Units, preventive Health, etc. Also responsible for the management and functioning of Medical and Health infrastructure of the state and ensuring their optimal utilisation. Develop necessary strategies as well as policies, procedures and systems for curative and preventive health throughout the state. Overall responsibility for the Preventive and Curative Health of the people of the state and the best use and development of available infrastructure.

Duties, Responsibilities and Authorities:

- Develop a comprehensive strategic plan for the department which includes vision, mission, objectives, goals of the department
- Ensure that quality curative health care services are available to the target population , Ensure adequate population/bed ratio, physician/bed ratio as per norms is maintained (Government of India / WHO / state government
- Handle all the policies relating to the administration and implementation of Various National Health programmes in the state such as RCH, Leprosy eradication and control of TB, Malaria and Blindness.
- The DGHS office will maintain a functional relationship with Directorate of Medical Education and Directorate of Indian System of Medicine regarding their activities.

- Co-ordinate with the Commissioner of Public Education, Director for Development of Handicapped and the Heads of Municipalities and Corporations on all the matters relating to Public Health.
- Co-ordinate with the Project Administrators of the various externally aided projects with various departments of Directorate of Health & Family Welfare to ensure smooth functioning of these projects.
- Ensure efficient administration and implementation of policy issues for computerisation and Management Information Systems at Department of Health & Family Welfare
- Responsible for submission of various policy and project proposals to the government. Commissioner of Health to receive the reports from Additional Director – Planning and after review submit the same to the Principal Secretary – Health & Family Welfare Department.
- Administer the matters relating to service and transfers of Group "A" officers of the department and also responsible for taking disciplinary action against them.
- Responsible for constitution of various committees from time to time and frame policies for nominations.
- To function as a member on all the programme implementation committees of the Department of Health & Family Welfare.
- To collect the documents pertaining to the Assets and Liabilities and implementation reports from the Joint Directors.
- Approve capital expenditure proposals within the powers delegated to him, put up other proposals for approvals by the respective authorities, periodically review the capital expenditure projects and ensure that the original plans are being adhered to
- Responsible for administration of the vigilance cell in the state.
- Provide the professional leadership, guidance and support to his immediate subordinates as well as other senior officers who work with them and enable the building up of a cohesive team that works in the overall interests of the state

Main Accountabilities:

- Overall quality of health care in the state
- Balanced and equitable availability of basic health facilities
- Proactive measures for epidemic control
- Controlling cost of services of providing health
- Development of norms / standards for service quality
- Professional delivery of medical and public health services
- Budget performance of the department
- Achievement of state health goals such as IMR.MMR.CPR etc
- Number of problems resolved effectively
- Functioning and timely completion of externally aided projects

- Timely address to the natural calamities and effective gearing up to meet any untoward incidents

Training Areas:

- Attend Management Development Programmes at International Institutes such as Harvard, John Hopkins, etc in areas of Public Health, health policies, New business models and management techniques in Health care.
- Study Health care facilities and delivery system in both developed and developing countries and also attend national and international seminars and conferences and to share the experiences of Karnataka and get a feedback.

Job Title: **DIRECTOR - MEDICAL**

Reporting To: **Commissioner**

Immediate Level Subordinates:

- Additional Director – Medical
- Additional Director - NCD

Basic Function:

Overall responsibility for establishing, managing and development of hospital infrastructure in the state. Is responsible for the curative services delivered at hospitals in the state. He is also responsible for developing and implementation of rational drug policy including the essential drug list for the state. Monitor distribution of drugs throughout the state in the hospitals.

Duties, Responsibilities and Authorities:

- Develop a comprehensive strategic plan for the medical wing of the department which includes vision, mission, objectives, goals of the department
- Ensure that quality curative health care services are available to the target population
- *Ensure adequate population/bed ratio, physician/bed ratio as per norms is maintained (Government of India / WHO / state government)*
- Ensure that the hospitals, dispensaries, Maternal homes and referral hospitals are easily accessible to the population, review need for rationalisation and relocation of some health units as well as setting up new health units in order to improve accessibility and service coverage.
- Review and evaluate the existing policies and procedures and work methods by means of periodic and special studies
- Review the MIS reports generated by AD – Medical / Planning and take corrective actions
- Review and recommend the upgradation of health infrastructure in the state

- Work out improved methods and procedures to achieve the objectives of the hospital
- Develop standards, methods and measurements of the hospital activities
- Monitor the utilisation of hospital resources throughout the state and adopt means of bringing optimum utilisation
- Ensure periodic health promotion activities (quantifiable) are carried out in the hospital
- Be a member of the accreditation board to certify standards in hospitals, both in private and government hospitals
- *Ensure that all hospitals have a disaster management plan of action*
- Visit all district and major hospitals in the state, atleast once a year
- Ensure that medical audit and internal audit has been carried out in all hospitals at periodic intervals
- Submit all relevant material which can be hosted on the department website
- Ensure that full economy and expenditure control is observed in all clinical (curative) related operations and activities of hospitals in the state.
- ***Recommend transfer and postings of District surgeons and Superintendents of Major Hospitals.***

Main Accountabilities:

- Ensure quality of care in all government hospitals through periodic medical audit and patient satisfaction surveys
- Ensure optimum capacity utilisation of hospital infrastructure through periodic review of MIS reports (hospital efficiency indicators) of all hospitals
- Increase of health infrastructure (need / technology based) in the state in coordination with planning cell
- Ensure that there is no mis-match of specialists and all posts are identified in hospitals as per norms of the bed capacity of the particular hospitals and also ensure full complement of staff
- Visit all District hospitals atleast once in a year to monitor their functioning and utilsation of resources

Training Areas:

- Attend Management Development Programmes at international institutes such as Harvard, John Hopkins, etc in areas of Public Health Policies, health policies, New business models in Health care.
- Study Health care facilities and delivery system in both developed and developing countries and also attend national and international and to share the experiences of Karnataka and get a feedback.

Job Title: **ADDITIONAL DIRECTOR - MEDICAL**

Reporting To:

- Director - Medical

Immediate Level Subordinates:

- Joint Director – Medical
- Joint Director – Pharma (GMS)
- Joint Director – Hospital

Basic Function:

Overall responsibility for effective medical care at different hospitals in the state, looking after the transfer policy of the state cadre doctors including the specialists. Monitor the effective utilisation of hospital and medical facilities throughout the state and following the drug policy guidelines throughout the state.

Duties, Responsibilities and Authorities:

- Upgradation of facilities at district level institutions and other institutions having bed strength of 200 and above other than those institutions coming under the control of the Directorate of Medical Education.
- Adhering to wherever statutory obligations applicable regarding setting up/maintaining of hospitals in the state
- District hospitals attached to medical colleges will also be under the perview of office of Director – Medical Services
- Planning, implementation, Monitoring, reviewing evaluation and all matters relating to upgradation, sanction of additional beds, sanction of additional staff etc.
- Policy matters related to establishment of hospital pharmacy Units, Govt. Medical stores, Health equipment, Drugs & matter relating to Department rate contracts on drugs and equipment.
- Assists the government in the implementation of medical staff by laws.
- Matters connected with non-communicable diseases such as Cancer control, Hospital psychiatric clinics, diabetes control programme and other similar diseases.
- Responsible for coordination in all areas of operation in the hospital
- Monitor effective implementation of hospital infection control
- ***Policy matters relating to medical reimbursement, constitution of medical boards etc.***
- ***Monitor*** medical care facilities to VIPs (***as organised by JD***)., visiting the State and arranging medical facilities in the various special functions (Sports/ congregations of Spl. Festivals/ Melas etc.,).
- *Work in coordination with Additional Director – Planning to identify the number of specialist posts for the next five years at regular intervals in different hospitals of the*

state and take steps to groom the existing doctors by recommending for Post Graduate Course or any refresher course.

- Ensure optimum utilisation of the manpower resources attached to him, organize and / or arrange to organize training programmes to augment skills and attitudes, appraise performance of employees, counsel employees and contribute to overall growth and development of the staff directly attached to him, recommend increments, promotions, transfers, etc.
- *Continuous monitoring of the performance of the personnel at different hospitals and recommend for any training required.*
- *Monitor the utilisation of hospital resources (space planning, physical infrastructure, capacity utilisation of beds, etc) and equipment.*
- *Study the MIS reports and decide on any corrective actions.*
- *Responsible for conducting medical audit by appropriate personnel*
- *Hold periodical quality assurance meetings for effective* review
- Aware of all legislative provisions which affect his work area. Ensure that the reporting staff is also doing this. Also ensure that all tasks and operations of his departments are carried out within the framework of the laws, statues, rules, orders and procedures as may be stipulated from time to time.
- Monitoring the policy matters relating to organ transplantation, and matters relating to Corpus fund

Main Accountabilities:

- Pay visit to all District hospitals and other major hospitals atleast once in a year to check the proper usage of allotted resources and find out reasons for need for upgradation of resources.
- Complete the record of medical audits conducted on a sample basis in the state and show the corrective actions taken
- Conduct internal audit for the processes related to a particular functionary in the department in a major hospital and suggest means to improve that.
- Suggest for proper demand estimation for the specialists in different hospitals of the state
- Plan and indent for the equipment required for diagnosing and treatment of different kinds of NCD cases
- Monitor the working of referral system in the state
- Coordinate with the office of AD – Planning in identifying the number of specialists required from time to time

Training Areas:

- MDP in hospital administration from reputed institutes and study tours of well managed hospitals abroad
- Process of conducting internal and medical audit

Job Title: **JOINT DIRECTOR - MEDICAL**

Reporting To: **Additional Director – Medical**

Immediate Level Subordinates:

- Deputy Director - Medical

Basic Function:

Oversee the treatment and availability of doctors for all kinds of human ailments and their effectiveness in delivering the best medical care

Duties, Responsibilities and Authorities:

- Recommendation for establishment of hospital pharmacy Units, procuring health equipment, Drugs and other matters relating to Department rate contracts on drugs and equipment in coordination and consultation with Joint Director – Pharma, Joint Director – Procurement, Joint Director - Hospital and Joint Director – Equipment & Maintenance as and when the need arises
- Arrange infrastructure for non-communicable diseases such as Cancer control, Hospital psychiatric clinics, diabetes control programme and other similar ailments and of mental health, de-addiction programme, old age programme, anti-smoking, de-addiction, hypertension, etc, in coordination with Procurement division of the department.
- Matters relating to medical reimbursement, constitution of medical boards etc.,
- Constituting medical boards for first appointment of all appointments in the state.
- Constituting medical board for unauthorised absence or long leave certification, change of cadre, etc
- **Medical audit and quality assurance of hospitals**
- Monitor effective implementation of hospital infection control
- Inspection of hospitals to monitor their physical / equipment / staff for implementation of special programmes such as organ transplant, etc. (special acts as member of the appropriate authority)
- Inspection regarding customs duty exemption

- *Monitor the flow of information regarding the availing of medical information at different hospitals to the office of Additional Director – Planning's office for generating MIS information and using it further for social science research and any interpretations for better service*
- Study the MIS reports and decide on any corrective actions.
- Monitor the process of handling the medico-legal cases in different hospitals.
- Providing medical care facilities to VIPs., visiting the State and arranging medical facilities in the various special functions (Sports/ congregations of Special Festivals/ Melas etc.,).
- Monitor all matters relating to Corpus fund (Chief Minister's fund)

Main Accountabilities:

- Proper deployment of doctors during special festivals and melas. To see that no disease spreads due to the lapses from the doctors.
- Effective utilization of Corpus fund
- Visit all district Hospitals and atleast - CHC/TH (quantifiable) in a year and report the existing facilities there to AD Medical

Training Areas:

- Conducting medial audit and internal audit
- Hospital Personnel management (emphasis on Organizational Behavior/motivation)

Job Title: **DEPUTY DIRECTOR – MEDICAL**

Reporting To: **Joint Director – Medical**

Immediate Level Subordinates:

- District surgeon
- Superindent of major hospital

Basic Function:

First source for the Joint directors and above officers in the department to solicit information about the quality of health care and the implementation of different government sponsored schemes for the poor and needy in the state.

Duties, Responsibilities and Authorities:

- Regularly review the quality of health care provided at various health units in the state such as clinics, Maternal homes, dispensaries and referral hospitals by undertaking regular visits to them along with the heads of those units.
- Ensure the flow of information regarding the availing of medical information at different hospitals to the office of Additional Director – Planning's office for

generating MIS information and using it further for social science research and any interpretations for better service.

- Review the working of different schemes of government for the poor to avail good treatment at the government hospitals
- Ensure proper maintenance of all medical records, documents and files in his department.
- Ensure proper up-keeping and maintenance of assets assigned to the department situated at all locations
- Support any activity related to medical audit initiated anywhere in the department
- Recommend medical audit for the cases involving any irregularity specifically found out on routine inspection
- Monitor effective implementation of hospital infection control
- Monitor the cleanliness of hospital programme to maintain the hygienic conditions
- Monitor all matters relating to Corpus fund (Chief Minister's fund)

Main Accountabilities:

- Visit all district hospitals and major hospitals atleast once in a year and conduct enquiries about availability of specialists at the required time
- Suggest ways and means of availing the specialists' services at remote places in the state (by means of transfers which can be worked out)

Training Areas:

- Conducting medical audit
- Administration of personnel

Job Title: **JOINT DIRECTOR - PHARMA**

Reporting To: **Additional Director – Medical**

Immediate Level Subordinates:

- Deputy Director – Pharma

Basic Function:

Functionally the reference authority in the department for any drugs and pharmaceuticals related issue. Oversee the functioning of Government Medical Stores and pharmacies handling different volumes located at different hospitals in the state including the staffing matters at the respective locations.

Duties, Responsibilities and Authorities:

- Monitor the process of taking requisitions from different hospitals for replenishing the stocks of pharmaceuticals and the other related policy matters.
- Planning, implementation, monitoring and reviewing of various activities connected with the procurement and disbursement of drugs.
- Review of Stock position of drugs and equipment in the pharmacies located ***in the government hospitals and*** Government Medical Stores and distribution as per annual indents.
- Oversee the mandatory guidelines in employing the pharmacists in hospitals
- Work in coordination with and directions from Drug Controller regarding the policies and regulations.
- Approve setting up of pharmacies in different hospitals
- Provide information as required to Drug Controller
- Proper documentation of matters relating to Expert committee and High Power Committee meetings and finalisation of rate contracts on drugs and equipment and follow up action.
- Preparing / updating essential drug lists for use at various levels such as PHC / CHC /TLH / DH and other hospitals.

Main Accountabilities:

- Proper logistics in procuring the drugs and vaccines
- Proper logistics in disbursing the drugs as the requirement is, at different places
- Conduct inspection visits to all district hospitals and major hospitals in the state to monitor the working of pharmacies in those respective locations.
- Effective addressing of any sudden requirement of life-saving drugs or problems during epidemics/natural calamities

Training Areas:

- Statutory obligations with the Drug Controller's office
- Logistics in handling drugs and related materials

Job Title: **JOINT DIRECTOR – HOSPITAL**

Reporting To: **Additional Director – Medical**

Immediate Level Subordinates:

- Deputy Director – Hospital (N)
- Deputy Director – Hospital (S)

Basic Function:

Monitor basic infrastructure facilities in all the hospitals and review the requirements for any upgradation to meet the specified standards. (Coordinate with District Medical Officer in taking up this activity). Monitor the working of nursing staff and address to their requirements and suggestions in upgrading the delivery of health services to the people of the state.

Duties, Responsibilities and Authorities:

- *Recommendation for establishment of hospital pharmacy Units, procuring health equipment, Drugs and other matters relating to Department rate contracts on drugs and equipment in coordination and consultation with Joint Director – Pharma, Joint Director – Procurement, Joint Director - Hospital and Joint Director – Equipment & Maintenance as and when the need arises*
- Overall incharge of hospital functioning, infrastructure and patient facilities throughout the state.
- Responsible for inter-hospital coordination at all occasions, especially during any exigencies or outbreak of epidemics in the state.
- Responsible for nursing activity and any coordination with external agencies like Red Cross (India) whenever the need arises.
- Monitor the cleanliness of hospital programme to maintain the hygienic conditions
- Plan regarding the hospital waste disposal in consultation with the office of AD Urban health and Commissioner, municipal authorities
- Up-keeping of district level institutions and other institutions having bed strength of 100 and above other than those institutions coming under the control of the Directorate of Medical Education.
- Planning, implementation, monitoring, reviewing evaluation and all matters relating to upgradation, sanction of additional beds, sanction of additional staff etc.,
- Monitor the flow of information regarding the availing of medical information at different hospitals to the office of Additional Director – Planning's office for generating MIS information and using it further for social science research and any interpretations for better service.
- Monitoring of Medical audit and internal audit of all the hospitals
- Ensuring the patients charter of rights

Main Accountabilities:

- All the infrastructure related requirements within the budgeted framework are met within 6 months of raising the requirement from any District surgeon / DHO, routed through DD Hospital

- Hygenic conditions in the hospital and effective hospital waste disposal norms as specified by the concerned authorities from time to time

- Planning, implementation, monitoring, reviewing evaluation and all matters relating to upgradation, sanction of additional beds, sanction of additional staff etc.,
- Monitor the flow of information regarding the availing of medical information at different hospitals to the office of Additional Director – Planning's office for generating MIS information and using it further for social science research and any interpretations for better service.
- Monitoring of Medical audit and internal audit of all the hospitals

Training Areas:

- Hospital planning (any designs, apart from functioning)
- Hospital administration
- Hospital waste disposal and treatment

Job Title: **DEPUTY DIRECTOR – HOSPITAL**

Reporting To: **Joint Director - Hospital**

Immediate Level Subordinates:

- Coordination with District Surgeons
- Lay secretaries of hospitals

Basic Function:

Ensure optimum utilization of hospital facilities and are maintained according to the standards specified by central and state governments from time to time.

Duties, Responsibilities and Authorities:

- Ensure that the health care services available to the target population is adequate
- Ensure that the dispensaries, Maternal homes and referral hospitals are easily accessible to the population as per the directives of central government
- Review need for rationalization and relocation of some health units as well as setting up new health units in order to improve accessibility and service coverage.
- Monitor the cleanliness of hospital programme to maintain the hygienic conditions

- *Ensure the flow of information regarding the availing of medical information at different hospitals to the office of Additional Director – Planning's office for generating MIS information and using it further for social science research and any interpretations for better service.*
- Continuous monitoring of the performance of the personnel at different hospitals and recommend for any training required.

Main Accountabilities:

- Proper utilization of hospital resources / infrastructure
- Visit all government hospitals and major hospitals atleast once a year and monitor the utilization of hospital resources by the concerned people
- Ensure proper hospital waste disposal

Training Areas:

- Hospital administration
- People Management
- Monitoring technology improvements in other parts of the world

Job Title: **ADDITIONAL DIRECTOR - NCD**

Reporting To: **Director – Medical**

Immediate Level Subordinates:

- Joint Director – Opthalmology
- Joint Director – NCD (Cardiology and Diabetology)
- Joint Director – Traumotology
- Joint Director – Mental Health
- Joint Director - Oncology

Basic Function:

Implementation and Monitoring of national programmes of NCD, proper treatment for all kinds of NCD diseases such as Cancer, diabetes, heart ailments and trauma in different hospitals in the state.

Duties, Responsibilities and Authorities:

- Suggest for proper demand estimation for the specialists in different hospitals of the state
- Identify the magnitude of the problem of NCD cases
- Plan and indent for the equipment required for diagnosing and treatment of different kinds of NCD cases
- Monitor the working of referral system in the state

- Coordinate with the office of AD – Planning in identifying the number of specialists required from time to time
- Ensure proper storing of radio-active material at different hospitals, used in the treatment of cancer
- Inform the target number of posts in the fifth successive year to Director – Medical and suggest the means of getting such numbers into the system.
- Review the MIS reports from time to time and suggest corrective actions to the concerned Surgeons and other officials in the department
- Study the developments around the world in the treatment of different kinds of Human ailments and pass on the knowledge to different functionaries in the department
- Encourage participation of the doctors in their related national and state health programmes and work hand-in-hand with the office of District Health officer
- Identify the potential levels of the doctors in the Medical health department and suggest for any refresher/continuous learning courses for them from time to time
- Conduct medical audit on sample basis for some cases and compulsorily for all the controversial cases.
- Monitor effective implementation of hospital infection control
- Coordinate with the office of Additional Director – Planning
- Ensure implementation of Blindness Control Programme, Mental Health Programme

Main Accountabilities:

- Visit all the district and other major hospitals in the state atleast once a year
- Ensure implementation of Blindness Control Programme, Mental Health Programme
- Identify the magnitude of the problem of NCD cases
- Conduct medical audit on sample basis for some cases and compulsorily for all the controversial cases

Training Areas:

- Health Management
- Hospital management
- Programme management

Job Title: **JOINT DIRECTOR - OPHTHALMOLOGY**

Reporting To: **Additional Director – NCD**

Immediate Level Subordinates:

- District Surgeons
- Eye specialists in the state
- Other National Blindness Control Programme officers of the district
- District Health Officer

Basic Function:

Oversee the National Blindness Control Programme in the state and ensure proper staffing pattern in the ophthalmology department in different hospitals in the state. Also ensure adequate care for the ophthalmology related patients and high success rate during any operation. Identify the magnitude of the problem of blindness cases

Duties, Responsibilities and Authorities:

- Planning, implementation and monitoring of programmes connected with National Programme for control of Blindness.
- Identify the magnitude of the problem of blindness cases
- Training of Ophthalmic Assistants.
- Matters pertaining to calling for tenders for drugs, equipment related to ophthalmology.
- Ensure conducting of medical audit for some operations on a sample basis and compulsorily for critical and controversial operations
- Coordinate with District Officers in spreading the message of good nutrition for control of blindness among the people of the state
- Review of working of Major equipment
- Continuous monitoring of the performance of the personnel at different hospitals and recommend for any training required.
- Monitoring the activities related to District Blindness Societies
- Monitor the effectiveness of eye-camps conducted
- Review the hygienic conditions in the eye-operation theaters and eye-wards
- Monitoring the eye transplantation operations performed in different hospitals
- Coordination with NGO's working in the field of blindness control

Main Accountabilities:

- Medical audit of eye operations conducted either at special camps or hospitals
- Visit all hospitals which have the facility for eye-operation in the state, atleast once a year.

- Imparting training to Laboratory Technicians and Food Inspectors.
- Dispense the authority and submit reports pertaining to consumers protection Act.
- *Monitor the activities pertaining to food and water analysis in coordination with pollution control board and local-self bodies.*
- International certification on Health related matters for issue of passports and Visa
- Generate and submit analytical reports on various samples of epidemiological importance including samples received from Lokayukta.

Job Title: **ADDITIONAL DIRECTOR – URBAN HEALTH**

Reporting To: **Commissioner / DGHS**

Immediate Level Subordinates:

Basic Function:
Coordinate with local self bodies in planning to create hygenic conditions in urban areas and slums. Work in coordination with pollution control authorities in planning for anti-pollution activities. Passing of stringent norms from time to time regarding the disposal of hospital waste.

Duties, Responsibilities and Authorities:
- Promote urban sanitation among all the municipalities and corporations in the state with special emphasis on urban slums
- Be in touch with corporation/municipalities commissioners and Chief Executive of Zilla Parishad through the department functionary and monitor the sanitation/health activities throughout the state
- To create awareness of personal hygiene and to maintain a better environment for prevention of diseases
- Recommend policies in handling the waste generated from different hospitals.
- Create amicable platform for interaction between the department of health and Public Health Engineering functionary of different corporations and municipalities
- Coordinate with the Project Directors of different national Programmes

Training Areas:

Health management

Programm management

Job Title: **DIRECTOR – EXTERNAL AIDED PROJECTS (EAP)**

Reporting To: **Commissioner / DGHS**

Immediate Level Subordinates:

Basic Function:
Guide the department in securing the national and international projects by concerned bodies and see thay they are properly executed without any mis-appropriation of funds.

Duties, Responsibilities and Authorities:
- He/She and his team of officers are responsible to implement the project. He is also designated as ex-officio Additional Secretary to Govt to enable to issue Government orders on all the related matters.
- Shall carryout such of the functions which are assigned by the steering committee and Project Governing board
- Coordinate with different functionaries / departments in Central / State government in meeting the project requirements.
- Monitor the usage of funds released for the purpose of the project
- Monitor the effectiveness of different Externally Aided Projects in the state
- Appraise different project reports which are submitted by state department of health which are prepared to seek financial/any kind of help from outside the government functionary

Main Accountabilities:
Effective usage of funds released
Timely completion with desired / planned results

Training Areas:
- Project management
- Coordination and Administrative skills

Job Title: **DIRECTOR – PROCUREMENT & MAINTENANCE**

Reporting To: **Commissioner / DGHS**

Immediate Level Subordinates:
- Chief Engineer – Civil
- Joint Director – Procurement
- Joint Director – Equipment & Maintenance (Bio-Medical)

Basic Function:
Being overall incharge of the physical asset base of the department should take utmost care in procuring as per the requirement and properly maintaining them. Procurement skills as per the norms of the funding agencies

Duties, Responsibilities and Authorities:

- *Pass the bill of payment for the land accumulated / procured for different constructions to be taken by the Department of Health & RCH*
- *Approve the procurement and release payment for hospital equipment which are of value above the level of authorisation by the Joint Director in the department*
- *Monitor the effective utilisation of all machinery / equipment / buildings, etc and their longevity.*
- Provide managerial inputs in selection of any kind of construction or procurement of equipment
- Work for coordination between all the technical functionaries of the department
- Monitor the procurement procedures and processes from time to time
- Monitor and approve for Procure, install, commission, maintain and service bio-medical and other hospital equipment for diagnosis, monitoring, analysis and therapy, etc
- Work in coordination with funding agencies and manufacturers of equipment and follow the conditions agreed upon.
- Oversee the transfer of works from procurement functionary to the maintenance functionary.

Main Accountabilities:

- *Monitor the effective utilisation of all machinery / equipment / buildings, etc and their longevity.*
- Provide managerial inputs in selection of any kind of construction or procurement of equipment
- Work for coordination between all the technical functionaries of the department
- Monitor the procurement procedures and processes from time to time
- Monitor and approve for Procure, install, commission, maintain and service bio-medical and other hospital equipment for diagnosis, monitoring, analysis and therapy, etc
- Work in coordination with funding agencies and manufacturers of equipment and follow the conditions agreed upon.

Training Areas:

- Appraising global tenders
- Coordination & Administrative skills

Procurement skills as per the norms of the funding agencies

Job Title: **JOINT DIRECTOR – PROCUREMENT**

Reporting To: **Director – Procurement & Maintenance**

Immediate Level Subordinates:

Basic Function:
Procure all kinds of equipment other than related to pharmacy and Government medical stores, after properly studying the reliability of the manufacturer and efficient after-sales service. Ensure the requirement of the equipment to be procured by suggesting a better indenting, sanctioning and approving authority to procure them. Procurement skills as per the norms of the funding agencies

Duties, Responsibilities and Authorities:
1. *Understand / study the equipment needs and provide atleast basic utilities wherever required*
2. *Select the equipment based on technical evaluation*
3. *Ensure proper chanellisation of indenting, approving and sanctioning of the procurement of equipment.*
4. *Monitor the installation, commissioning and acceptance of the machinery and equipment for the department*
5. *Signing the service provider contract for training wherever applicable before purchase of equipment and inform Deputy Director – Equipment training.*

Main Accountabilities:
Procurement skills as per the norms of the funding agencies

Training Areas:
- Apprising of Global Tenders
- Logistics

Job Title: **CHIEF ENGINEER - CIVIL**

Reporting To: **Commissioner / DGHS (Administratively)**
Secretary PWD department (Functionally)

Immediate Level Subordinates:

- Superindent Engineer (Bangalore)
- Superindent Engineer (Dharwad)
- Dy.Chief Architect

Basic Function:

Ensure quality construction and maintenance work for the Department of Health in the state. Ensure proper appraisal of tender documents for allotment of construction work to the eligible parties. Work in coordination with appropriate authorites in finalisation of the design of hospitals

Duties, Responsibilities and Authorities:

- He receives the indent for work from the department of Health and RCH and executes that with the help of his functionaries in coordination with the concerned officials in the department
- He is the overall incharge of all the civil works in the state which are related to the Department of Health and RCH
- Obtaining architectural drawings estimates and sanctioning administrative and technical approval to execute the works
- Coordinating various departments on land and civil works
- Monitoring construction programme and suggest necessary mid-term corrections and actions
- Planning for maintenance of existing buildings

Job Title: **DEPUTY CHIEF ARCHITECT**

Reporting To: **Chief Engineer – Civil (Administratively)**
Chief Architect – Karnataka (Functionally)

Immediate Level Subordinates:

- Executive Engineer – Civil

Basic Function:

Prepare drawings and designs of the department constructions in connivance of the concerned authorities in the department

Duties, Responsibilities and Authorities:

- Heads the design wing of the Department of Health & RCH, Government of Karnataka
- Prepares the plan for the structure of buildings as per the felt need and allotted budget by the department

Main Accountabilities:

- Optimum space utilisation in the civil works of the state Department of Health & RCH

Training Areas:

Hospital architecture

Job Title: **SUPERINDENT ENGINEER – CIVIL**

Reporting To: **Chief Engineer – Civil**

Immediate Level Subordinates:

- Executive Engineer - Civil

Basic Function:

Monitor the construction work of Department of Health & RCH as per the specifications given and ensure the quality in construction

Duties, Responsibilities and Authorities:

- Executes the approved civil work from the department of Health and RCH and executes that with the help of his functionaries in coordination with the concerned officials in the department
- He is the overall incharge of all the civil works in the region specified which are related to the Department of Health and RCH
- Obtaining architectural drawings estimates and sanctioning administrative and technical approval to execute the works
- Suggest for release of payment for satisfactory completion of works according to the norms of the state PWD department
- Coordinating various departments on land and civil works
- Supervising and Monitoring construction programme and suggest necessary mid-term corrections and actions
- Planning for maintenance of existing buildings

Job Title: **JOINT DIRECTOR – EQUIPMENT & MAINTENANCE – BIO MEDICAL**

Reporting To: **Director – Procurement & Maintenance**

Immediate Level Subordinates:

- Deputy Director – Equipment Training
- Deputy Director – Equipment (DHS)
- Deputy Director - Transport

Basic Function:

Organize for periodic schedules of preventive maintenance of the equipment of the department, monitor the response time in attending the breakdown enquiries and take corrective action. Organize for training the internal technicians to work on the new machinery and follow-up with OEMs for maintenance and training.

Duties, Responsibilities and Authorities:

- Any activity relating to after installation of equipment, like conveying the precautions to be taken in operating certain equipment, etc to the technicians
- Organise for training from the service provider or the OEMs regarding the operation of the equipment by the technicians
- Monitoring the periodic schedules of preventive maintenance
- Less response time for breakdown maintenance
- Organize for training the internal technicians itself in tackling the minor breakdowns
- Plan for alternative equipment in case of a major shutdown of one equipment
- Release of budget for regular maintenance and any such other activities

Main Accountabilities:

- Effective training by Original Equipment Manufacturers for whatever the commitment has been at the time of purchase
- Less response time in attending to any maintenance / shutdown problem

Training Areas:

- Coordination with external agencies
- Preparation of maintenance schedules

Job Title: **ADDITIONAL DIRECTOR – N.KARNATAKA REGION**

Reporting To: **Commissioner / DGHS**

Immediate Level Subordinates:

- District Health Officers of Bijapur, Raichur Gulbarga, Belgaum, Bidar, Bagalkot, Bellary, Koppal districts
- All national and state Programme officers of Bijapur, Raipur, Gulbarga, Belgaum, Bidar, Bagalkot, Bellary, Koppal districts
- The Joint Directors handling different national and state health programmes at the directorate

Basic Function:

The office of Additional Director – North Karnataka Region acts as a nodal officer for coordinating the efforts of various functionaries in the department in showing the special emphasis for a faster upliftment of the health conditions in the region. His office also identifies various special programmes as and when required to bring development in the area specified

Duties, Responsibilities and Authorities:

- Overall coordinating authority of all the programmes and projects in the districts of Bijapur, Raipur, Gulbarga, Belgaum, Bidar, Bagalkot, Bellary, Koppal both in the areas of Medical Health and Public Health
- Identify the additional budget allocation areas for the region allotted
- Head the office of the nodal office for the districts specified as a group
- Coordinate with the offices of all national and state programmes and monitor their implementation in the districts specified
- Coordinate with the office of AD - Planning and obtain the MIS reports about the health standards from time to time to review the progress in the districts specified
- Frequently visit the District and other speciality hospitals in the state and review the public health and medical care in the districts specified
- Coordinate with the municipal and other local bodies and monitor the urban health activities.
- Identification of any new projects and programs for speedy upliftment of health standards in the districts specified

Main Accountabilities:

- Should visit all the district hospitals and other major hospitals in the districts specified atleast twice in six-months period
- Speedy implementation of all health programmes

Job Title: **ADDITIONAL DIRECTOR - PLANNING**

Reporting To: **Commissioner / DGHS**

Immediate Level Subordinates:

- Joint Director – Planning
- Joint Director – Research
- Joint Director - MIS

Basic Function:

Oversee the planning process in the department regarding the different areas of health and hospital management in the state of Karnantaka. Obtain and review MIS reports related to different aspects in managing the department like availability of doctors, bed occupancy, population-bed ratio in a particular region, etc. Plays visionary role to the department and suggest future plans periodically. Suggest any improvements/corrective actions in managing the department to the concerned functionaries according to their job responsibilities

Duties, Responsibilities and Authorities:

- Review the growth pattern in the state and plan the requirements in the health sector accordingly
- Develop strategic and perspective plan for the department
- Develop short-term and long-term budgetary plans for the department
- Suggest the appropriate authorities about the corrective actions to be taken if any shortfall is observed in their functioning
- Approve the areas for research

Receive the information on Health of people and different hospitals in the state and review them for preparing proper MIS .

Main Accountabilities:

Training Areas:

Planning methodology
Medical systems

Job Title: **JOINT DIRECTOR - PLANNING**

Reporting To: **Additional Director - Planning**

Immediate Level Subordinates:

- Deputy Director – Planning
- Deputy Director - Training

Basic Function:

Obtain reports from different functionaries regarding the status of medical and public health in the state and suggest for improvements along with the path to follow. Collates all the information generated through MIS activity and process for future planning.

Duties, Responsibilities and Authorities:

- Plan for the issues pertaining to institutions coming under the control of the District Health and RCH and Zilla Parishads as regards upgradation, improvement and strengthening of existing facilities and the outlayed budget for them.
- All service matters relating to the District Health and RCH officers Class I Senior and Deputy Directors
- Formulate the inputs required for National Nutrition Programme in coordination with all the functionaries in the department at the district level
- Suggest the health projects under the State Plan Programme
- Review and suggest actions based on monthly multilevel review reports and Karnataka 20 point programme
- Review the follow-up of special component plan and tribal sub-plan
- Suggest issues and review the draftnotes for Governer's address and finance minister's budget speech
- Preparation of Annual Administrative Reports, Annual Report, Status Report and all matters relating to Bureau of Health Intelligence including Sushrusha Programme.
- Formulate matters relating to Tribal Sub Plan, Special component plan and Karnataka Twenty Point Programme.

Job Title: **JOINT DIRECTOR - RESEARCH**

Reporting To: **Additional Director - Planning**

Immediate Level Subordinates:

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Basic Function:

Identify the areas of contemporary importance to the department and recommend for research by various agencies / persons

Duties, Responsibilities and Authorities:

- Follow the trends in medial and health care in the state
- Recommend for research / action research in the areas identified
- Follow up with the findings

- Recommend for any future directions or corrective actions for policy makers or other people concerned

Main Accountabilities:

Training Areas:

- Research methodology
- Action research

Job Title: **JOINT DIRECTOR - MIS**

Reporting To: **Additional Director – Planning**

Immediate Level Subordinates:

- Statastician
- Demographer
- All programme officers at the district level (administratively)

Basic Function:

Collate all the hospital, medical and health related information in the state through different hospitals and analyse them for any interpretation.

Duties, Responsibilities and Authorities:

- Head of office to analyse the information about all hospitals in the state
- Monitor the information generation at different hospitals regarding the treatment of patients, availability of beds for inpatients, population-bed ratio, etc
- Collate and interpret information about occurrence of epidemics in different parts of the state
- Coordinate with all the programme officers at districts in the state and collate information they generate about the status of programme and the health condition in the state
- Coordinate with all the DHOs and District Surgeons in collecting the information about the status of their work and inturn the health systems in the state

Training Areas:

- Research Methodology
- Primary and secondary data collection
- Report writing
- Coordination skills

Job Title: **CHIEF ADMINISTRATIVE OFFICER**

Reporting To: **Commissioner / DGHS**

Immediate Level Subordinates:

Basic Function:

Duties, Responsibilities and Authorities:

- Guide the relevant authorities relating to Cadre strength of the department.
- Preparation of Annual programme of inspections in the state
- Maintenance of inspection reports after the inspection of officers.
- All matters relating to establishment of all the cadres of the department, obtaining sanctions of the Director and other officers of the Directorate such as Additional Directors, Joint Directorate etc., wherever such sanctions required as per the delegation of powers issued by the Government from time to time.
- All matters relating to filling up of the vacancies promotions, declaration of probationary period disciplinary proceedings, compassionate appointments, time-bound advancements, sanction of leave etc., after obtaining sanctions of the Director/ Additional Directors/ Joint Director, where such sanctions are required.
- All matters relating to Legislative Assembly/ Council including answering Legislative Assembly/ Council questions and parliamentary questions, and all standing committee meetings of the Legislature
- furnish replies to the other house committees of the Legislature.
- Constitution of board of visitors in the Department

Main Accountabilities:

Training Areas:

Public Administration
Cadre management
Transfer policy
Office organization
Time management

Job Title: **CHIEF ACCOUNTS OFFICER (FINANCE)**

Reporting To: **Chief Administrative Officer – Finance**

Immediate Level Subordinates:

Basic Function:

Duties, Responsibilities and Authorities:

- *Report all matters relating to financial aspects of the Department both plan and non-plan to the higher officials in the finance/accounts department*
- Reconciliation of expenditure of plan and non-plan schemes.
- Obtain reimbursements from Govt. of India, pertaining to Centrally sponsored schemes, Externally
- Report about the expenditure regarding aided projects and Central sector schemes.
- Settlement of House building advance, vehicle advance, L.T.C., HTC., sanction of pension, DCRG, issue of No due certificates etc.,
- Payment of salaries of the staff of the Directorate of Health and F.W. Services.
- *Audit of expenditures in different sections of the department*
- *Report about the transactions from the treasury to the higher officials*
- Public Accounts Committee, Estimate committees and other House committees, relating to finances.
- Monitoring of Plan schemes including MMR and preparation of performance budget.

Main Accountabilities:

Training Areas:

Job Title: **JOINT DIRECTOR - TUBERCULOSIS**

Reporting To: **Additional Director – CMD**

Immediate Level Subordinates:

- Deputy Director – Bactriology
- Deputy Director – Epidemiological Surveillance Unit
- DHO
- District TB officer

Basic Function:

Effectively monitor the National TB Control Programme and Aids control programme.

Duties, Responsibilities and Authorities:

- Plan the activities to be taken up regarding National TB control programme
- Coordinates with IEC department in educating the masses about the care to be taken against the spread of Tuberculosis
- Monitor the activities under the TB control Programme at the district level
- Coordinate the NTBCP activities at different districts and strive for their joint efforts wherever possible
- Monitor the treatment of AIDS patients in the state
- Submit the reports to the MIS department for proper evaluation of the effectiveness of different activities under the programme
- Look after the activities of Lady Wellington TB Demonstration and Training Centre and other TB related programmes or institutes in the state
- Monitor the treatment to Aids infected patients in the state.
- Get aware of the social hazards being faced by the Aids patients and pass the information to IEC unit and other departments to educate the masses in avoiding those
- Monitor and evaluate the effectiveness of treatment to the TB infected patients
- Monitor proper usage of funds allocated for treatment of TB patients and for various activities under National TB control Programme
- Assess the requirement of personnel in handling the TB related activities from time to time, as the requirement of District Surgeon and District Health Officer and communicate to the appropriate authority

Main Accountabilities:

Training Areas:

Job Title: **DEPUTY DIRECTOR (PHARMACY)**

Reporting To: **Joint Director (Medical)**

Immediate Level Subordinates:

Basic Function:

Monitor the functioning of different dispensaries and pharmacies situated in all the hospitals in the state. Monitor timely distribution of pharmaceuticals to the dispensaries and their proper storage as per the mandatory norms. Plan for the availability of pharmacists wherever required

Duties, Responsibilities and Authorities:

- *Follow-up of matters connected with Pharmacy units at different locations regarding sending proposals for establishment of Pharmacy/ units, maintenance of pharmacy equipment / blood banks, etc.*
- *Monitor the maintenance of standards in preserving blood, drugs and medicines at the government pharmacies.*
- All matters relating to selection of drug samples in Govt. Medical stores, District stores and other institutions for maintenance of quality standards and arranging analysis in the drug controller's office
- *Receive requisitions from different pharmacies in the state.*
- *Monitor the financial limits of each pharmacy in the state and disburse the drugs*
- *Obtaining permission for procurement of drugs and medicines for different pharmacies in the state.*

Main Accountabilities:

- Timely distribution of drugs to the pharmacies and dispensaries in government hospitals in the state

Training Areas:

- Logistics management
- Indian Drug and Cosmetics Act

Job Title: **DEPUTY DIRECTOR - TRAINING**

Reporting To: **Joint Director – Planning**

Immediate Level Subordinates:

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Basic Function:

Identify the means of aligning the Department's short-term and long-term goals with that of the individual's aspirations and development, offer career planning options and provide induction training and as well the refresher programmes for the people in the department

Duties, Responsibilities and Authorities:

- understand the organization's short-term and long term goals and the expectations from the people in the department
- understand the people's aspirations and provide options to link it to the career planning
- counsel the individuals and provide options for their growth
- Plan for the induction training for the new entrants into the system, coordinate with SIHFW
- Plan for any refresher courses for the technical as well as non-technical people in the department to keep them abreast with the latest knowledge

Main Accountabilities:

- Conduct induction training programme for all the new entrants into the system
- Cover atleast 5 % of the doctors strength in each year for the refresher training course

Training Areas:

- Career counseling methods
- Knowledge about the options available for further growth of the doctors

DISTRICT LEVEL

Job Title: **DISTRICT HEALTH AND FW OFFICER**
Reporting To: **Respective Program Directors and joint Directors of different functionaries of the department.**

Immediate Level Subordinates:

- District Malaria Officer
- District Cholera Combat team officer
- District Leprosy Officer
- District Training officer (to coordinate with SIHFW)
- District Surveillance Unit Officer (District epidemiologist)
- District TB Officer
- Regional Assisstant Chemical Examiner

Basic Function:

Head of all the activities related to Department of Health & FW of Government of Karnataka at the respective district level. Acts as the single reference point for any information related to public and medical health in the district. Would be coordinating between different functionaries and program / project offices for effective implementation in the district.

Duties, Responsibilities and Authorities:

- All matters relating to Medical institutions in the district except those which are controlled by the Dist. Surgeons and Director of Medical Education.
- Responsible to carry-out activities relating to Health and RCH programmes in the State
- Responsible for Administrative and technical aspects of all the activities and programmes of the directors of different functions in the department.
- Responsible for state government for any queries regarding the health (e.g: spread of epidemic) of the people in the state
- Work as per the instructions issued by the Director of Health & FW services, from time to time.
- Overall responsibility of all the Family Planning activities in the district, in addition to the other Health programmes. Responsible Administratively and technically to the Commissioner - Health
- In consultation with the M.O.H.F. (FW & MCH) he will draw up advance annual and monthly programmes in order to achieve the targets fixed.
- He will visit the IUD and Sterilisation camps and satisfy himself that proper arrangements are made.
- He will see that timely action is taken by the M.O.H. (Family Planning & MCH) regarding stocking and distribution of supplies and equipment.

- He will be responsible for the proper use of all the departmental vehicles for the Family Planning Programme without hindering the programmes for which the vehicles are allotted .
- During the visits to the various Primary Health Centres apart from paying attention to various other schemes, pay particular attention to the Family Planning Programme to see that progress of work is achieved and to take action against such of those who are slake, with a view to gear up the work.
- Arrange for one of the senior members of his staff namely Asst. Director Health Officer, Medical Officer of Health (FP), District Extension Educator, Health Supervisor or District Nursing Supervisor to attend the monthly conference of each primary Health Centre and review the physical progress achieved.
- Arrange a quarterly conference of all Medical Officers under his/her control and review the progress of the Family Planning Programme.
- Responsible to see that the required reports are sent to the State Family Planning Bureau every month by the due date.
- In coordination with the Medical Officer of Health (FP & MCH) he/she will arrange job orientation training for the peripheral staff.
- Responsible for the random check-up of atleast 5% of persons who have IUD placements or sterlisation operations done in the district by Government Institutions). Voluntary organisation and Private practitioners to ensure that the incentives are not misused, and that proper follow up has been ensured.
- He will have full control of his annual budget and will be responsible for expenditure therefore within his powers without recourse to higher authorities thus ensuring that the budget provisions do not lapse.

Main Accountabilities:

Training Areas:

Job Title: **DISTRICT SURGEONS/SUPERINTENDENTS OF MAJOR HOSPITALS**

Reporting To: **District Health Officer**

Immediate Level Subordinates:

- Respective specialists in the hospitals
- Administrative Medical Officer
- Functionaries at CHC and THC
- Nursing supervisor
- Chief pharmacist (Functionally)

Basic Function:

Duties, Responsibilities and Authorities:

- He will be the head of institution and exercise administrative and technical control over the staff of the institution.
- Maintain the quality of patient care according to the standards laid down by the medical care / state government
- Submit to the state government (Office of AD / JD) at intervals, reports on the quality of medical care and working of the medical staff
- Act as an ex-officio member of the management team, be involved in the day-to-day decisions of the hospital at the operating level (can a management team comprising of DHO, DS, CEO ZP and ZP chairman to work at the district level)
- Schedule duties, help scheduling of operating room and any other medical or paramedical services under his/her administration
- Enforce staff rules and discipline the doctors in consultation with the DHO
- Sign hospital medical certificates, reply to correspondence and queries about patients, medical services and paramedical services under his jurisdiction
- Conduct performance review of doctors in consultation with the DHO
- Sanction of leave for Doctors and other functionary who are under his/her office and reporting to him.
- Out patient and in-patient services, Diagnostic services of day-to-day patients.
- Procurement of drugs as per the requirement received from the chief pharmacist in the district/hospital, in consultation with the DHO.
- Issue fitness certificates, old age pension eligibility certificates and physically handicapped to whoever eligible and required

Job Title: **RESIDENT MEDICAL OFFICERS**

Reporting To: **District Surgeon / Superindent of major hospitals**

Immediate Level Subordinates:

Basic Function:

Duties, Responsibilities and Authorities:

- Monitoring of the maintenance of Drug stores in the hospitals and the availability of medicines as per the requirement of doctors and patients
- Diet supplies of the institution to the inpatients as per mandatory stipulations (clarify)
- Addressing the medico-legal cases and be responsive to the requirement of law & order authorities in answering the queries along with district surgeon.
- Arranging of Casualty services outpatient services, maintenance of cleanliness in the institutions.
- Maintenance of punctuality, discipline, maintenance of environment sanitation in the institution.
- Posting of staff for day-to-day work, providing Ambulance services on requisition, maintenance of Log book etc.,
- Maintenance of the equipment in the institution.

Main Accountabilities:

Training Areas:

Job Title: **TALUK HEALTH OFFICER**

Reporting To: **District Health Officer**

Immediate Level Subordinates:

- TLH/CHC/PHC- AMO/MOH/LMO

Basic Function:

Duties, Responsibilities and Authorities:

- Implement all National Health programmes in the taluks through a net work of primary Health centres and other institutions.
- Report day-to-day status of Health condition prevailing in the taluk including epidemics to higher authorities.
- He/she is the reporting authority of all the periodical returns the Taluk duly received from the peripheral institutions and provide feed back to the peripheral institutions & the DH & FWO.
- Exercise supervisory control of all the institutions in the Taluk.
- Represent DHO in Taluk / Panchayat meeting and Gram Panchayat meetings wherever necessary and co-ordinates all the activities of the department such as organising. Eye camps, control of communicable diseases, Sushrusha programme, Malaria control programme, RCH camps, Immunization, T.B. Leprosy and other related matters.
- Arrange for proper distribution of drugs, equipment, materials as supplied by DH & FWO and maintain inventory of all articles received in the Taluk and its proper maintenance.
- Conduct periodical inspection of the institutions and report the matter to the DH& FWQ on all observations made.
- Plan, manage and implement national health & RCH programmes in the Taluk
- Inspect all health organizations on regular basis
- Developmental planning of health institutions
- Sanction casual, normal and restricted leave to all Medical Officers as and when required.
- Prepare confidential reports on Medical Officers and statistical reports of the Taluk.
- Plann steps to prevent the communicable diseases and report the same to District Health & RCH Officers and revenue officers in the Taluk.
- Inspect stores of all health institutions and raise indents with District levels offices for the various medicines and chemicals required for these institutions.
- Organise family planning and eye test camps

- Conduct monthly meetings with Primary Health Centre (PHC), Primary health Unit (PHU) and Community Health Centre (CHC) and review the implementation of various plans.
- Conduct meetings with other departments in the Taluk and co-ordinate in their functioning
- Issue certificates for conducting the various festivals and fairs in the Taluk and take steps to ensure control on diseases.

Any other duties assigned by DH&FWO.

JOB TITLE: **SENIOR HEALTH ASSISSTANT**

REPORTS TO: **Medical Officer (PHC)**

IMMEDIATE LEVEL SUBORDINATES

- Junior Health Assistant (Male)

DUTIES, RESPONSIBILITIES AND AUTHORITIES

- Supervise and guide Junior Health Assistant (Male) in rendering the health care services to the community.
- Strengthen the knowledge and skills of the Junior Health Assistant (Male) and also in planning and organising his programme of activities and also prepare assessment reports on him.
- Co-ordinate the activities with those of Junior Health Assistant (female) and other health personnel including Health guides and Dais.
- Assist the medical Officer of the PHC in conducting training programmes for various categories of health personnel.
- Check and indent for the procurement of supplies and equipment at the subcentres.
- Responsible for proper storage of drugs and maintenance of equipment at the subcentre.
- Responsible for scrutinising the maintenance of records by Junior Health Assistants and consolidation of the reports to the Medical officer of the PHC.
- Supervise the work of Junior Health Assistant (Male) during concurrent visits and check 10% of the houses in the village to verify the work.
- Responsible for taking blood smears, radical treatment and spraying of insecticides for controlling Malaria
- Responsible for identification for Kala-azar, Communicable diseases, Leprosy, Tuberculosis and ensure that appropriate control measures are taken.
- Inform the Medical Officer PHC about the defaulters to treatment in cases of Leprosy, tuberculosis etc.
- Help the community in the construction of soakage pits, manure pits, compost pits, sanitary latrines, and safe water sources and also supervise the chlorinating of wells.
- Supervise the immunisation of all children from one to five years and pregnant women.
- Assist Medical Officer PHC in organising Family planning camps and drives and motivate & follow-up cases for family planning.
- Ensure that all cases of malnutrition among children are given necessary treatment and refer serious cases to the PHC.

- Carry out educational activities for control of communicable diseases, environmental sanitation, MCH, Family planning, nutrition, immunisation, dental care and other national health programmes.
- Collect and compile the weekly report of births and deaths occurring in the area and submit them to the Medical Officer PHC.
- Organise and conduct training of community leaders with the assistance of the health team.
- Provide treatment for minor ailments and first aid for accidents and emergencies and refer cases beyond his competence to the PHC.

PARTICIPATION IN COMMITTEES / MEETINGS

- Staff Meetings at PHC
- Fortnightly meetings with Junior Health Assistants at subcentres.

MAIN ACCOUNTABILITIES

JOB TITLE: **SENIOR HEALTH ASSISTANT (FEMALE)**

REPORTS TO: **Medical Officer (PHC)**

IMMEDIATE LEVEL SUBORDINATES

- Junior Health Assistant (Female)

DUTIES, RESPONSIBILITIES AND AUTHORITIES

- Supervise and guide Junior Health Assistant (Female), Dais and female health guides in the rendering of health care services to the community.
- Strengthen the knowledge and skills of the Junior Health Assistant (Female) and also in planning and organising her programme of activities and also prepare assessment reports on her.
- Carryout supervisory home visits in the areas under National health programmes.
- Supervise a referral of all pregnant women for VDRL testing to CHC/Sub-divisional hospital.
- Assist the medical Officer of the PHC in conducting training programmes for various categories of health personnel.
- Check and indent for the procurement of supplies and equipment at the subcentres.
- Responsible for ensuring that the Junior Health Assistant (Female) maintains a general kit and midwifery kit and Dai kit and the clean and proper maintenance of subcentres.
- Responsible for scrutinising the maintenance of records by Junior Health Assistant (Female) and consolidation of the HMIS reports to the Medical officer of the PHC.

- Supervise the work of Junior Health Assistant (Female) during concurrent visits and check 10% of the houses in the village to verify the work.
- Conduct weekly MCH clinics at each sub centres with the help of Junior Health Assistant (Female) and Dais.
- Conduct deliveries when required at PHC and provide necessary domiciliary and midwifery services.
- Conduct weekly family planning clinics at each subcentre and motivate resistant cases for family planning.
- Provide information on services for medical termination of pregnancy, sterilisation and refer the cases for MTP to the approved institutions.
- Help Medical officers in school health services.
- Supervise the immunisation of all children from one to five years and pregnant women.
- Assist Medical Officer HC in organising Family planning camps and drives and motivate & follow-up cases for family planning.
- Ensure that all cases of malnutrition among children are given necessary treatment and refer serious cases to the PHC.
- Carry out educational activities for control of communicable diseases, environmental sanitation, MCH, Family planning, nutrition, immunisation, dental care and other national health programmes.
- Organise and utilise Mahila Mandals, teachers and other women in the community in the RCH programmes including ICDS personnel.

PARTICIPATION IN COMMITTEES / MEETINGS

- Staff Meetings at PHC
- Fortnightly meetings with Health Workers at subcentres.

MAIN ACCOUNTABILITIES

JOB TITLE: **JUNIOR HEALTH ASSISSTANT (FEMALE)**

REPORTS TO: **Senior Health Assistant (Female)**

IMMEDIATE LEVEL SUBORDINATES **N.A.**

BASIC FUNCTION

DUTIES, RESPONSIBILITIES AND AUTHORITIES

- Register and provide care to pregnant women through out the period of pregnancy
- Ensure that the pregnant women undergo all the necessary tests like VDRL test
- Conduct about 50% of the total deliveries, supervise deliveries conducted by Dais and refer the cases of abnormal pregnancy to Health Assistant Female or the PHC.
- Responsible for post delivery visits and advise the mother about the maternal and child health, family planning, nutrition and immunisation and diarrhoea control.
- Assess the growth and development of infant and take necessary action to rectify the defect.
- Responsible for spreading the message of family planning to the couples and distribute conventional and oral contraceptives to the couples.
- Identify women leaders in the area for promoting RCH programmes and participate in Mahila Mandal meetings and utilise such gatherings for educating women in RCH programmes.
- Identify women requiring medical termination of pregnancy and refer them to the approved institutions and educate them about the services.
- List the dais in the area and help the Health Assistant in training them.
- Notify the Medical Officer PHC about the abnormal increase of communicable diseases and administer presumptive treatment wherever necessary.
- Maintain all the records relating to register of pregnant women from three months onwards, Maternal and child care records and submit prescribed monthly report to the Health Assistant (Female)
- Co-ordinate the activities with Health Worker (Male) and other health workers including the Health guides and Dais.
- Help the medical officers in school health services.

PARTICIPATION IN COMMITTEES / MEETINGS

- Staff Meetings at PHC/Community Development Block

MAIN ACCOUNTABILITIES

JOB TITLE: **JUNIOR HEALTH ASSISSTANT (MALE)**

REPORTS TO: **Senior Health Assistant (Male)**

IMMEDIATE LEVEL SUBORDINATES N.A.

BASIC FUNCTION:

DUTIES, RESPONSIBILITIES AND AUTHORITIES

- Identify the people affected with Malaria and take the blood smears and begin presumptive treatment under NMEP.
- Co-ordinate with the village health guides about the spray dates for the insecticides and intimate the houses in the village.
- Enquire about the presence of Kala-azar, Japanese Encephalitis etc and will guide the suspects to the PHC or CHC for diagnosis and treatment.
- Identify the cases of communicable diseases, Tuberculosis and Leprosy inform the Health Assistant (Male) and Medical Officer (PHC) about these cases and also undertake the control measures.
- Undertake chlorinating of public water sources at regular intervals and educate the community on environmental sanitation.
- Administer DPT vaccine, oral polio vaccine, measles vaccine and BCG vaccine to all the infants and children in his area in collaboration with Health Worker Female.
- Assist the Health worker female in administering the immunisation to all pregnant women, and also for school immunisation programme
- Educate the people in the community about the importance of immunisation against the various communicable diseases.
- Responsible for spreading the message of family planning to the couples and distribute conventional and oral contraceptives to the couples.
- Identify male community leaders in the area and train them for promoting RCH programmes.
- Identify women requiring medical termination of pregnancy and refer them to the approved institutions and inform the Health Worker (Female)
- Identify cases of malnutrition among the children and arrange for necessary treatment and educate the parents about the nutritious diet.
- Provide treatment for minor ailments and first aid for accidents and emergencies and refer cases beyond his competence to the PHC.
- Enquire about births and deaths occurring in his area and report to the Health Assistant (Male)

- Prepare maintain and utilise family and village records, maps and charts of the village, record of people undergoing treatment for TB and Leprosy and submit periodical reports to Health Assistant (Male)

PARTICIPATION IN COMMITTEES / MEETINGS

- Staff Meetings at PHC/Community Development Block

MAIN ACCOUNTABILITIES

JOB TITLE: **LABORATORY TECHNICIAN**

REPORTS TO: **Medical Officer - PHC**

IMMEDIATE LEVEL SUBORDINATES N.A.

BASIC FUNCTION

DUTIES, RESPONSIBILITIES AND AUTHORITIES

- Maintain the cleanliness and safety of the laboratory
- Ensure that the glassware, microscope and equipment are kept clean and well maintained.
- Ensure Sterlisation of equipment as and when required.
- Ensure the safe disposal of specimens and infected material.
- Maintain the necessary records of investigations done and submit the reports to the Medical Officer, PHC.
- Prepare monthly reports regarding his work and submit to the Medical Officer, PHC.
- Indent for supplies required at the laboratory through the Medical Officer, PHC and ensure the safe storage of the received material.
- Carry out examination of urine, stools, blood, sputum, skin and smears for leprosy patients, semen, throat swabs, drinking water and aldehyde test.
- Responsible for maintenance of all records and slides examined by him for Malaria and get them confirmed by the Medical Officer, PHC
- Maintain the daily progress and output register of blood slide examination and a backlog chart of pending radical treatment under NMEP.

PARTICIPATION IN COMMITTEES / MEETINGS

- Staff Meetings at PHC

MAIN ACCOUNTABILITIES

JOB TITLE: **MEDICAL OFFICER – PHC**

REPORTS TO: **Taluk Health Officer / District Health Officer**

IMMEDIATE LEVEL SUBORDINATES **Health Assistants (M/F)**

DUTIES, RESPONSIBILITIES AND AUTHORITIES

1. Organise the dispensary, outpatient department and allot duties to the ancillary staff to ensure smooth running of OPD.
2. Attend to the cases referred to him by Senior Health Assistants, Junior Health Assistants, Health guides and Dais from sub-centre level and refer the cases needing specialised medical attention to referral institutions.
3. Visit the subcentres in the area once in a fortnight to supervise the work and provide curative services.
4. Ensure that the health team is fully trained in various national health & RCH programmes and prepare the operational plans for ensuring effective implementation as per the targets.
5. Provide basic MCH services, implement nutrition and universal immunisation programmes
6. Responsible for proper and successful implementation of Family Planning programmes like Vasectomy, Tubectomy, IUD and MTP in the PHC area.
7. Responsible for administrative and technical matters relating to Malaria Eradication & Vector control programmes in the PHC area.
8. Responsible for all anti Kala-azar and anti Japanese Encephalitis operations in his area.
9. Responsible for regular reporting to District Malaria Officer/Civil Surgeon in terms of monitoring, record maintenance and maintenance of adequate provisions of drugs etc.
10. Provide facilities for early detection and cases of Leprosy, Tuberculosis, and blindness and ensure that all cases take regular and complete treatment.
11. Responsible for control of communicable diseases and the proper maintenance of sanitation in the villages and take action in case of any outbreak of epidemic.
12. Ensure that all the cases of STD are diagnosed and properly treated and provide facilities for VDRL test for all pregnant women at the PHC.
13. Visit various schools for ensuring health programmes,
14. Proper management of cases of diarrhoea and referral of serious cases to the hospitals.
15. Responsible for organising and conducting training under Medical and Para Medical personnel scheme and school health service schemes.

PARTICIPATION IN COMMITTEES / MEETINGS

- Staff Meetings at PHC

MAIN ACCOUNTABILITIES

JOB TITLE: **LADY MEDICAL OFFICER**

REPORTS TO: **Medical Officer, PHC**

IMMEDIATE LEVEL SUBORDINATES **Health Assistants & Health Workers**

DUTIES, RESPONSIBILITIES AND AUTHORITIES

1. Ensure that all the necessary steps are being taken for the control of communicable diseases in the village and report the outbreak of an epidemic to Medical Officer in-charge.
2. Responsible for diagnosing and treating Kala-azar and Japanese Encephalitis patients and also for arranging spray activities in the area under the supervision of Medical Officer in-charge at PHC.
3. Supervise and guide Health Assistants and workers in effective implementation of Maternal and Child Health, immunisation programme, family planning and nutrition programmes.
4. Arrange for the medical check-up at schools and treatment of students found to have defects.
5. Ensure that all the steps are being taken for provision of safe drinking water and improvement of environmental sanitation at the villages.
6. Participate in community involvement in the nutrition programme and safe water supply and environmental sanitation programmes.
7. Responsible for organising camps, meetings, health education talks, and involve Health Assistants and workers in these activities promoting health education.
8. Organise and conduct training for health guides, primary school teachers and dais for field training in community health programmes.
9. Assist Medical Officer, PHC in staff development and training programmes for staff at PHC, subcentres
10. Assist Medical Officer, PHC in conducting field investigations for planning changes in strategy for effective delivery of health services.
11. Ensure adequate supply of kits, medical drugs, contraceptives, vaccine, equipment etc at PHC and subcentres.
12. Obtain the reports from the periphery, analyse and interpret the data and utilise the finding for successfully implementing the health programmes in the area.
13. Scrutinise the work plans of Health Assistants and Health workers and supervise the maintenance of the prescribed records at the subcentre level.

PARTICIPATION IN COMMITTEES / MEETINGS

- Village Health Committee/Village Panchayat Meetings
- Monthly Staff meetings at PHC

JOB TITLE: **BLOCK EXTENSION EDUCATOR**

REPORTS TO: **District Health Education Officer**

IMMEDIATE LEVEL SUBORDINATES

DUTIES, RESPONSIBILITIES AND AUTHORITIES

1. Collate information on MCH, Rural development education, social welfare and other programmes and utilise the same for programme planning.
2. Collect and maintain data on mortality, protection and immunisation rates and utilise the same for work under FW & MCH programme.
3. Co-ordinate with the local voluntary agencies for training in health and RCH and will assist the Medical health officer in conducting these programmes.
4. Maintain complete set of education aids for training purposes.
5. Act as a resource person at the block level FW committee and ensure proper functioning of these committees in the catchment area of PHC.
6. Liason with the media units of other departments, NGOs and organise mass communication programmes like film shows exhibitions, lectures, dramas with the help of District Health Education Officer.
7. Responsible for all educational, motivational and communication programmes in PHC area.
8. Ensure supply and utilisation of information and educational material to health workers and development functionaries including those of voluntary agencies.
9. Support, guide and supervise the field workers in the area of information dissemination, education and motivation.
10. Give special attention to resistant couples and drop out by problem solving methods and committees.

PARTICIPATION IN COMMITTEES / MEETINGS

- Block level RCH Meetings
- Monthly Staff meetings at PHC

MAIN ACCOUNTABILITIES

JOB TITLE: **DISTRICT PUBLIC HEALTH EDUCATION OFFICER**

REPORTS TO: **District Public Health Officer**

IMMEDIATE LEVEL SUBORDINATES

- Block Health Educators
- Block Extension Educators

BASIC FUNCTIONS:

Evaluate the requirement, plan and execute the health education among the people in the district. Should use his offices to educate the people and thus suggest any precautionary/remedy measures for sort of issue, which can be addressed easily. Should effectively use any melas / any big gatherings of people in spreading the message.

All the matters relating to the Health Education will be routed through him/her to the District Health & F.P. Officer. He/she is the Technical Assistant to the District Health & FP. Officer, in Health & Family Education matters.

DUTIES, RESPONSIBILITIES AND AUTHORITIES

1. Evaluate the health education related requirements among the people in the district and submit reports to the office of Joint Director – Health Promotion and DHO
2. Plan and co-ordinate all the health education activities in the district in collaboration with official and non-official agencies.
3. Determine the relative applicability of the different communication methods including traditional media, in relation to the local circumstances and ensure through feedback to All India Radio, State Health Education Bureau, State Mass Media Wing the contents of such communication are locally relevant and effective.
4. Guide the Block Health educator in preparing talking points.
5. Assess the needs of the educational equipment and materials and arrange for their procurement/ production, maintenance, distribution and utilisation in the Health Centre.
6. Plan alternate approaches in Health Education and arrange for extra inputs through different media depending upon the needs.
7. Assist the State Health Education Bureau and Mass Media wing in identifying the areas of concern and conducting studies
8. Develop one Primary Health Centre as a Field study demonstration area in the District, preferably near to the district headquarters.
9. Solicit technical guidance and direction from the State Mass Media Wing and the State Health Education Bureau for reaching out to the people more effectively.
10. Arrange and conduct in-service training (job orientation) to the newly appointed field staff making use of the field study and demonstration material.
11. Identify special groups such as factory workers, plantation labour, government employees, teachers, etc and conduct orientation training involving medical officers of Health and paramedical workers in the Primary Health Centres.
12. Organise education campaign on occasions such as epidemics, family planning, immunization etc.
13. Organise exhibitions and cultural programmes at important centres during special occasions like festivals and fairs.
14. Supervise and guide the Block Health Education Officers and Block Extension Educators and arrange for the quarterly meeting.

PARTICIPATION IN COMMITTEES / MEETINGS

- Quarterly meeting with Block Health education officers and Block extension educators.

- Monthly meeting with the DHO to draw his attention for coordination between different functionaries in the district (PHC level to the district hospital).
- *Quarterly meeting with the Joint Director (Health Promotion) along with other District Health Education Officers to know the progress in other districts vis-à-vis theirs and discuss about any joint / mutually complementary programmes among themselves*

Arrange for quarterly meeting of the Block Health Educators at the District under the Chairmanship of District Health & F.P. Officer.

- Obtain and review the reports of Block Health Educators and Deputy Health Education Officers and submit a consolidated report to the District Health & FP. Officer
- Tour at least 15 days in a month and make ten night halts.
- Visit each PHC at least once in three months.

Training Areas

JOB TITLE: STAFF NURSE

REPORTS TO:

- Nursing Supervisor (Sister)
- Medical Officer in-charge PHC/CHC
- District Surgeon in District Hospitals

IMMEDIATE LEVEL SUBORDINATES

- Ward Staff

BASIC FUNCTION

Staff Nurse is a first level professional nurse who provides direct patient care to one patient or a group of patients assigned to her/him during duty shift, and assist in ward management and supervision.

DUTIES, RESPONSIBILITIES AND AUTHORITIES

- Responsible for admitting and discharging patients and maintain clean and safe environment
- Maintain personal hygiene and comforts of the patient and attend to the nutritional needs of patient and feed helpless patients.
- Perform technical tasks like administration of medication, assisting doctors in various medical procedures and the patient care.
- Update case sheet of patients under their care as per prescribed norms.

- Follow doctors' rounds and help them in diagnosis and treatment in the absence of Nursing Supervisor.
- Co-ordinate patients care with various health team members.
- Responsible for keeping the ward neat and tidy.
- Handover and takeover the patient and ward equipment and supply.
- Maintain safety of the ward equipment.
- Assist ward supervisor/sister in ward management and officiates in her/his absence and assist in taking inventories.
- Supervise students and other junior nursing personnel working with her/him and maintain ward record and reports assigned to her/him.
- Participate in clinical teaching both planned and incidental.
- Teach and guide domestic staff and help in orientation of new staff.
- Participate in staff education programmes and guide student nurses.

PARTICIPATION IN COMMITTEES / MEETINGS

-

MAIN ACCOUNTABILITIES

JOB TITLE: NURSING SUPERVISOR (SISTER)

REPORTS TO:

- Nursing Superintendent (hospitals above 400 bed strength) or
- Medical Officer in-charge (PHC/CHC) or
- District Surgeon (Other hospitals including District Hospital)

IMMEDIATE LEVEL SUBORDINATES

- Staff Nurse

BASIC FUNCTION

Nursing Supervisor is accountable for the nursing care management of a ward or a unit assigned to her. She is responsible to the Nursing Superintendent/Assistant Nursing Superintendent for her ward management. She takes full charge of the ward and assigns work for various categories of nursing and on-nursing personnel working with her. She is responsible for safety and comfort of the patients in her ward. In a teaching hospital she is expected to ensure good learning fields.

DUTIES, RESPONSIBILITIES AND AUTHORITIES

- Plan nursing care and make patients assignment as per their nursing needs.
- Assist in the direct care of the patient as and when required and to see the total health needs of her patients are met.
- ensure safety, comfort and good personal hygiene of her patient.
- take nursing rounds with staff and students and to ensure that proper observation records of the patients are made and necessary information imparted to the concerned authorities.
- Review case sheets updated by the staff nurses on a regular basis
- make rounds with doctors and assist him in diagnosis and treatment of his patients.
- implement doctor's instructions concerning patient treatment.
- assist patients and their relatives to adjust in the hospital and its routine and also co-ordinate patient care with other departments.
- ensure safe and clean environment for the ward
- Responsible for preparation of duty and work assignment plans, ward statistics, indent ward stores and check inventory at regular intervals.
- make list for condemnation of articles and submit to all the concerned.
- establish and reinforce ward standards prescribed in the procedures and manuals of the ward and the hospital and policies that are in force.
- act as a liaison officer between ward staff and hospital administration and also maintain good public relation in her ward.
- write confidential reports of her reporting staff.
- organise orientation programmes for new staff and guides in formulation of nursing care studies and nursing care plans etc.
- evaluate nursing students performance and submit reports to the school authorities.
- help in medical and nursing research.

PARTICIPATION IN COMMITTEES / MEETINGS

- Ward conferences and meetings

MAIN ACCOUNTABILITIES

- Hospital infection control
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JOB TITLE: **NURSING SUPERINDENT**

REPORTS TO: **Medical Superintendent**

IMMEDIATE LEVEL SUBORDINATES

- Nursing Supervisor (Sister)

BASIC FUNCTION

Nursing superintendent is responsible to the Medical Superintendent in a hospital having 400 or above bed strength. She s accountable for the safe and efficient running of the various Nursing departments in the hospital.

DUTIES, RESPONSIBILITIES AND AUTHORITIES

- Responsible for setting up the higher standard of professional conduct.
- Plan and administer rules and regulations to maintain efficient nursing services.
- Implement recommendations and regulations that are issued from time to time by DHS/DME or Medical superintendent of the hospital.
- Make regular visits to hospital kitchen and supervision rounds of all hospital wards and departments.
- Secure the necessary equipment, linen and ensure good nursing care.
- Receive reports from the night duty nursing supervisors and analyse them for any corrective actions
- Organise in-service education programme and orientation to new staff.
- Ensure adequate supply of cleaning materials and ensure cleanliness of hospitals and environment.
- Arrange for the proper disposal of hospital waste especially in relation to Hepatitis and HIV etc.
- Prepare budget for the nursing services in collaboration with the other staff.
- Sanction casual leave arrangements for warned leave and days off etc. for **????**
- Conduct the following activities for school of nursing attached to the hospital
  - Carry on periodical inspection of nurses' hostel and attend to the complaints and welfare of student nurses.
  - Counsel and guide the staff members and ensure discipline at nurses' hostel.
  - Ensure proper care of student nurses during illness and arrange for regular health checkup.
  - Assist school of nursing in selection of student nurses.
  - Arrange for teaching programme, practical experience and examinations in collaboration with the School of nursing.
- Responsible for maintaining attendance register, leave register, duty rosters and health records of the staff members.

JOB TITLE: **SENIOR PHARMACIST**

REPORTS TO: **Chief Pharmacist**
Administrative Medical Officer / Resident Medical Officer

IMMEDIATE LEVEL SUBORDINATES

- Junior Pharmacist

DUTIES, RESPONSIBILITIES AND AUTHORITIES

- Responsible for Main stores, Sub-Stores, Dispensary and I.V. Fluid sections.
- To ensure preparation and updation of the indents, day book of receipts, issue register, inventory stock book, Bin card, expiry date register, drug sampling, statistical data of demand and supply of drugs and test reports and inspection book at main stores, sub-stores, dispensary and I.V.Fluid manufacturing section.
- To verify in random the items received in respect to order placed, label specification, volume/weight/measurement with respect to label claims and for consistency.
- To carry out qualitative simple physico – chemical tests to ascertain the quality of drugs and maintain a record of such works and submit his observations to the Chief Pharmacist/ RMO / AMO and also about such drugs failing to pass the qualitative tests.
- To maintain the stores in clean and hygenic conditions.
- To keep all Poisonous drugs, expensive drugs, narcotic and psychotrophic drugs separately under lock and key as per technically viable administrative directions.
- Responsible for preparation of annual expenditure programme within the budget allocations and needs of the hospital.
- Responsible for disposal of expired drugs.
- To assist the Chief Pharmacist/Graduate Pharmacist in manufacturing and testing of I.V.Fluid including animal house maintenance.
- To prepare the mixutres and formulations and dispense the drugs as prescribed by the Medical Officer.
- To participate in various Health education programmes of the institution and in the therapeutic assessment of quality of drugs in the hospital.
- To attend to emergencies in the absence of Medical officer in rendering first aid and common ailments.
- To dispense the OPD drugs for common ailments without prescription in the absence of Medical officer in-charge.

DISTRICT HEALTH AND FAMILY PLANNING OFFICER.

a. He will be in overall charge of all the Family Planning activities in the district, in addition to the other Health programmes. Responsible Administratively and technically to the Director of Health & FP. Services and state Family Planning Officer.
b. In consultation with the M.O.H.F. (FP & MCH) he will draw up advance annual and monthly programmes in order to achieve the targets fixed.
c. He will visit the IUD and Sterilisation camps and satisfy himself that proper arrangements are made.
d. He will see that timely action is taken by the M.O.H. (Family Planning & MCH) regarding stocking and distribution of supplies and equipment.
e. He will be responsible for the proper use of all the departmental vehicles for the Family Planning Programme without hindering the programmes for which the vehicles are allotted.
f. During his visits to the various Primary Health Centres apart from paying attention to various other schemes, he will pay particular attention to the Family Planning Programme to see that progress of work is achieved and to take action against such of those who are slake, with a view to gear up the work.
g. He will be responsible to arrange for one of the senior members of his staff namely Asst. Director Health Officer, Medical Officer of Health (FP), District Extension Educator, Health Supervisor or District Nursing Supervisor to attend the monthly conference of each primary Health Centre and review the physical progress achieved.
h. He will arrange a quarterly conference of all Medical Officers under his control and review the progress of the Family Planning Programme.
i. He will be responsible to see that the required reports are sent to the State Family Planning Bureau every month before the due date.
j. I connection with the Medical Officer of Health (FP & MCH) he will arrange job orientation training for the peripheral staff.
k. He will be responsible for the random check up of atleast 5% of persons who have IUD placements or sterlisation operations done in the district by Government Institutions). Voluntary organisation and Private practitioners to ensure that the incentives are not misused, and that proper follows up has been ensured.
l. He will have full control of his annual budget and will be responsible for expenditure therefore within his powers without recourse to higher authorities thus ensuring that the budget provisions do not lapse.

GOVERNMENT OF KARNATAKA

TASK FORCE ON HEALTH AND FAMILY WELFARE

A Commissioned Research Study

REVIEW OF EXTERNALLY AIDED PROJECTS IN THE CONTEXT OF THEIR INTEGRATION INTO THE HEALTH SERVICE DELIVERY IN KARNATAKA

By

Dr. Ravi Narayan
Community Health Cell
367, Ist Main, Jakkasandra
Koramangala, Bangalore - 34

Content List

PROJECT REPORT: Review of Externally – Aided – Projects (EAPs) in the context of their integration into Health Service Delivery in Karnataka.

A: Introduction

Since the early 1970's the Karnataka Government has negotiated and received various grants and loans from international funding agencies, including the World Bank, for health related projects that supported the growth and strengthening of primary and secondary health care services in the state. These externally aided projects have had their own particular focus; objectives; framework; operational strategies; and management information systems geared to support and or enhance both quantitatively and qualitatively, different aspects of Health Sector Development in the state. Each of them has their own cycles of mid-term reviews and concurrent reviews. The Human Development in Karnataka Report 1999 described five of these (see box).

Currently there are however atleast ten major externally aided health projects in the state- IPP VIII, IPP IX, KHSDP, OPEC, KfW, RCH, RNTCP, NACO, NLEP, DAN-PCB being implemented through the Government and Directorate of Health and Family Welfare Services. In addition UNICEF has provided project support to different health related sectors including Child Development and Nutrition; Water and Environmental Sanitation; Education; Child Protection; Communications and Strategic Monitoring. For the purpose of this Review all UNICEF Projects have been taken together as one and NLEP has been left out for unavoidable reasons. Health related externally aided projects, e.g. for nutrition, water supply and sanitation, implemented through other departments are not included under the scope of this review.

The Karnataka Task Force in Health, while reviewing these projects in their interactive and informal discussions and deliberations have raised some important questions for review and enquiry:

i) What are the learning points from each of these projects?
ii) How can they be integrated into the health system incorporating beneficial points and avoiding distortions.
iii) What has been their experience concerning issues of sustainability, accountability and transparency.

In the late 1990's, policy researchers, academicians and decision-makers have also begun to seriously review the "piecemeal pursuit of separately financed projects" as against 'the evolving options of more appropriate sector wide approaches'. This is linked to the growing recognition of some of the problems associated with single

Important externally assisted health projects	
Karnataka Health Systems Development Project (KHSDP)	The Karnataka Health System Development Project is proposed to be implemented over five years (1996-2001) with assistance from the World Bank. Its main objectives are improvement in the performance and quality of health care services at the subdistrict and district levels, narrowing current coverage gaps and improving efficiency. Major components include improvement of the institutional policy framework, strengthening implementation capacity, development of a surveillance system, extension and renovation of all secondary level hospitals, improvement of their clinical effectiveness and establishment of a properly functioning referral system. The project outlay is Rs. 546 crores.
Kreditanstalt fur Wiederaufbau (KfW)	The KfW of Germany is financially assisting a project in the four districts of Gulbarga division with objectives similar to those of the KHSDP. The project outlay is Rs.59 crores of which 90% is being provided by KfW as a grant. The project was launched in 1998.
India Population project (IPP) VIII	IPP VIII is being implemented in the slums of Bangalore since 1993-94 with World Bank assistance. Major objectives are improvement in maternal and child health and reduction of fertility among the urban poor. Strategies adopted include involving the community, improving the quality of services provided by the City Corporation, strengthening existing delivery services, establishing new facilities and providing services at the doorsteps of the urban poor. The project cost is Rs.39 crores.
India Population project (IPP) IX	This is the fourth in the series of India Population projects following IPP I and IPP III. The project is under implementation since 1994 in 13 districts. The main objectives are reduction in the crude birth and death rates as well as the infant and maternal mortality rates and increase in the couple protection rate. Strategies adopted include the promotion, strengthening and delivery of services through the involvement of the community and improvement in the quality of services by providing training and strengthening the monitoring and evaluation systems. The project outlay is Rs. 122 crores.
Reproductive and Child Health Services (RCH) Project	The Reproductive and child Health Services Project marks a change in the existing culture of achieving targets by shifting to a policy of provision of quality services. The project helps clients meet their own health and family planning needs through the full range of family planning services. It is a natural expansion of the earlier child survival and safe motherhood programme which was under implementation till 1996. It also includes the treatment of reproductive tract infections, sexually transmitted infections and the prevention of AIDS. All the districts of the state are proposed to be covered under the project. The budget for RCH project for five years (1997-98 to 2002-03) is Rs. 190 crores.
Source : Human Development in Karnataka – 1999	

focus sector project assistance, which include:

- Fragmentation;
- Conflict and or duplication;
- Donor driven agendas;
- Recurrent operational costs;
- Undermining of national capacities,
- Lack of flexibility,
- Varying standards of provisions, and
- Issues of ownership.

This short-term interactive review has been undertaken to explore some of these issues and address these concerns in the context of the Task Force recommendations for the Health Sector development policy for the state.

Within the time constraints, the researchers have tried to achieve the following:

a) Review all the externally aided projects not just individually but in their collective context reviewing available documentation as well as interacting with programme managers.

b) Using a SWOT approach, trying to identify the key strengths, weaknesses as well as opportunities and threats (distortions) from all these projects.

c) Trying to do this review in such a way so that the stakes of programme managers and hopefully the Health Directorate to learn from project experience and address seriously the concerns and issues of sustainability and integration are enhanced especially by improving in-house capacity and system development.

(See Appendix "A" for Project protocol and issues and questions to be addressed.)

B: General Description of EAP's

Table I shows the 10 EAPS included in the review. From the table the following key general observations on EAP's in Karnataka can be made.

1. Number

- There are ten EAP's which contribute to the Health Service Delivery in the state. (NLEP has not been included in the review fully).

2. Programmes / Projects

- While some are state components of GOI programmes (RCH, RNTCP, NPCB, KSAPS, UNICEF); others are state level projects (eg. KHSDP, IPP – VIII, IPP – IX, KfW, and OPEC)

3. World Bank : Main player

- While UNICEF and DANIDA have been long standing partners since 1970's the World Bank has become the key partner now supporting six out of the ten projects (this is particularly so since the 1990's) and there is reason to believe that since the World Bank takes over as the key player the other funding partners are getting some what sidelined or ignored.

4. Grant to Loans in the 1990's

- While the earlier bilateral donors were providing grants like UNICEF and DANIDA, the trend in the 1990's has increasingly moved towards more loan component in the projects with varied interest rates and associated conditionalities. The World Bank support being mainly in this category it is therefore even more important today to ensure that these funds are utilized efficiently with greater accountability and transparency since if they were misutilised then we would have the double problem of ineffective utilization coupled with a debt burden.

- The German government (KfW) and the Organisation for Petroleum Exporting Countries through the OPEC fund have joined World Bank in supporting primarily infrastructure development. The former is a grant and the latter is a soft loan to be paid over a twelve year period after a five year initial gap.

5. Stand alone

- Each of these projects are relatively distinct entities with clear cut objectives, framework, programmes and though they have to be complementary or supplementary to each other due to overlap at the field level (similar districts, health centres, health teams) this is not at all emphasized in the project reports or

built into their outlines. There is a fair degree of compartmentalization and hence they mostly stand alone with little dialogue between projects and seldom visualized as smaller components of a larger strategic plan. Even though presently the KfW project utilizes the engineering division and other resources from KHSDP, this linkage was not originally planned and took place only because the ZP engineering divisions envisaged to make decentralised decisions could not maintain requisite standards.

TABLE - I

Externally Aided Projects in Health Service Delivery in Karnataka
GENERAL DESCRIPTION

S.No / Name	Year of Starting	Main Source of Funds*	Total Project Size**	Period
1. **India Population Project IPP VIII** (Family welfare - urban slums project)	1993-94	**World Bank** a. Improvement in MCH & Fertility Reduction in Bangalore's urban slums b. Extended to 11 cities and towns due to savings and differences in Foreign exchange conversion rates.	39 Crores (387.2million) Part Loan / Part Grant	1993-2001 (in phases)
2. **India Population Project IPP IX** (Strengthening of Family welfare and MCH services)	1994	**World Bank** Reduction in CDR/ CBR & IMR in Rural areas through PHC Strategy. (13 Districts)	122 Crores (1220.9million) Part Loan / Part Grant	Launched in 1994
3. Karnataka Health Systems Development Project (KHSDP)	1996	**World Bank** Improvement of Quality and Performances of Health care at District and subdistrict level	546 Crores (109 per year) Part Loan / Part Grant	1996 -2001 5yrs
4. Kreditanstalt fur Wiederaufbau(KfW)	1998	**KfW of Germany** Improvement of Quality and Performance of Health care at District and subdistrict level (Gulbarga Division 5 backward districts)	59 Crores (0.38 million DM) Grant	Launched in 1998

S.No / Name	Year of Starting	Main Source of Funds	Total Project Size	Period
5. Organisation of Petroleum Exporting Countries Fund for International Development (OPEC)	1991	**OPEC Fund** 350 Bed Multi specialty hospital in Raichur.	29.25 Crores (OPEC - 90% 25.7 crores) Soft loan	Agreement in 1991
6. Reproductive and Child Health Services (RCH) Project	1997	**World Bank** Improving Quality of Family Welfare Services	190 crores 38 crores/year. Part Loan / Part Grant	1997 – 98 - 2003
7. Karnataka States AIDS Control (Karnataka State AIDS Prevention society)	1999	**World Bank** Reducing the rate of growth of HIV infection in the state and in strengthening the states capacity to respond to HIV/ AIDS	7 Crores (2000-01) Part Loan / Part Grant	1999- 2004
8. Revised National TB control programme (RNTCP)	1994	**World Bank** Supporting new approaches to effective TB control in state using SCC/ DOTS and other components.	Phase III 18.3 Crores Part Loan / Part Grant	1994- Neelasandra 1998 Entire Bangalore corporation 1996 - Chitradurga Bellary Raichur Bijapur 1999 - Davangere Koppal Bagalkote
9. National Programme for control of blindness (DANPCB) now NPCB – K	1990	**DANIDA** To reduce prevention of blindness from 1.4% to 0.3% by 2000 AD	3 Crores 30 million Grant	Till 2001
10. UNICEF-GOK Programme of Cooperation in 2001.	1970's	**UNICEF** To promote comprehensive and holistic survival, growth and development of children in the state	6.3383 Crores (2001) Grant	UNICEF has been supporting concurrently since 70's.

* All these projects have a contribution from state or central government respectively.

** See Table V and VI for further details.

C: Project Goals, Focus and Distribution of EAP's

A perusal of **Table II** on the project goals, focus and distribution helps to identify certain significant trends.

1. Primary Vs Secondary

- 7 out of 10 projects support Primary Health care level while 3 out of 10 projects support secondary care level (one of three also support Tertiary care).

- If the project costs / budgets are taken into account as a sign of priority or emphasis then only thirty three percent (386 crores) is on primary care and sixty six percent (634 crores) focussed on secondary and tertiary care. (Using project size as a general indicator)

2. Comprehensive Vs Selective

- Within the Primary Health Care group two of the projects IPP IX and UNICEF are more comprehensive in their design focussed on 'Urban and Rural' primary health care and child health (and social development) respectively, but the remaining five are more selective primary health care strategies with RCH being a slightly more composite package and the remaining three being focussed vertically on single disease problem of AIDS, TB, and Cataract Blindness.

3. Population agenda

(apart from RCH) ? AIDS condom distr.

- Even IPP VIII and IPP IX are strongly driven by the Family planning or population agenda with health needs other than fertility related, getting much less focus.

4. Diversity and overlap

- When the objectives and goals of these EAP's are reviewed collectively then the following observations can be made (refer **Table II**)

  - Each project is relatively multidimensional with different components and strategies. At the implementation level some components get more emphasized than others.

  - The objectives vary from very general ones to very specific outcome oriented ones as seen in AIDS, TB, and Blindness control.

TABLE - II

Externally Aided Projects in Health Service Delivery Karnataka
OBJECTIVES/ FOCUS / REGIONAL DISTRIBUTION

S.No/ Name	Objectives/ Goals	Focus	Regional Distribution
1. IPP VIII	• Delivery of FW & MCH to urban poor and promote CS & SM. • Reduce Fertility rate and promote late marriages. • Promote male participation in FP. • Awareness and action for personal hygiene, better environment and prevention of diseases • Non Formal Education (NFE) and vocational training for women • Promote Female Education	• Urban Poor / Selective Primary Health Care focussed on FW+MCH+CSSM+	• Bangalore urban slums. • 0.851 million population of urban poor in about 500 slums in an area of 225 sq. kms.
2. IPP IX	• Implement a program sustainable at village level to reduce CBR, IMR and MMR and increase CPR (Couple protection rate) through • Involve community in promoting delivery of family welfare services. • Strengthen delivery of services by support to drugs, kits, supplies to TBA's SC and PHC, mobility of ANM's; buildings of center and residential accommodation. • Training to Personnel and TBA's, Community leaders and voluntary workers. • Strengthen Monitoring and evaluation by MIES (from district to state level)	• Rural (Family welfare and MCH) • Primary Health care Focus	• <u>Civil works Focus</u> Bellary, Chickmaglur, Dakshina kannada, Hassan, Kodagu, Mandya, Mysore, Uttar kannada, Shimoga, Chitradurga, Belgaum, Bijapur, Gulbarga • <u>IEC / MIES Focus</u> In all districts

S.No/ Name	Objectives/ Goals	Focus	Regional Distribution
3. KHSDP	• Improvement in performance and Quality of Health Care services at District and Subdistrict level • Narrowing the current coverage gaps by facilitating access to health care delivery. • Achievement of better efficiency in the allocation and use of health resources. By -Strengthening implementation capacity. - Strengthening delivery of service. - Improving functioning of referral. - Establishing effective surveillance system. - Improvement of cost recovery mechanisms. - Improving access to disadvantaged sections SC/ST/women	• Secondary level health care - To provide critical support to PHC Networks - Establish essential linkages with tertiary level.	• <u>Renovating = 70</u> CHC – 14 Taluk Hospital – 34 Sub Dist HQ Hospital – 9 District Hospital – 6 Women & Children Hospital – 5 Epidemic Diseases Hospital – 2 • <u>Extending = 131</u> CHC – 28 Taluk Hospital – 71 Sub Dist. HQ. Hospital – 16 District Hospital – 9 Women & Children Hospital – 6 Epidemic Diseases Hospital – 1 Grand Total = 201

S.No/ Name	Objectives/ Goals	Focus	Regional Distribution
4. KfW	• Significant Improvement in the Health status of socio-economic backward region / state. • Setting up a Comprehensive referral system in the division through strengthening and revamping secondary hospital network. • Sustainability of Infrastructure and Equipment. • Increase Sustainability of Health care.	• Secondary level Gulbarga district. (Northern disadvantaged districts) • Renovation and upgradation of facility. • Improvement of Maintenance • Improving Sustainability through fee collection.	• Gulbarga Division Bidar - 6 hospitals Bellary - 10 Gulbarga - 18 Raichur - 13 47 hospitals 26 in Phase One 21 in Phase Two
5. OPEC	• To build a 350 bed multi speciality hospital which will cater to Raichur District and four districts around. (Med/Surg/ENT/ ortho Physiotherapy, Cardiology / Cardiothoracic, Ophthal, Dental, Nephrology, Urology, Burns wards, Gastroentorology, Biochem, Path, Microbiology Radiology and CSSD).	• Secondary and Tertiary health care • Old District hospital will remain as a women and children hospital with skin, psychiatry, Leprosy and TB (250 beds)	• Raichur - / Gulbarga, Bidar, Gadag, Bijapur (and some neighbouring districts of AP will be benefited.
6. RCH	• To meet individual client health and family planning needs and to provide high quality services through a gender sensitive and responsive client based approach. • Aim to reduce the burden of unplanned and unwanted child bearing and related mortality and morbidity • Reducing 'unmet need' increasing 'service coverage' ensuring quality of care.	• Selective Primary Health Care with focus on Reproductive and child health. • Prevention and Management of unwanted pregnancies. • Maternal care - Antenatal - Natal - Post natal - Child survival - Treatment of Reproductive tract infections and STDs.	• All districts in 3 years. • Districts categorized into A, B, C category A = better off B = average C = weaker • 1st year = 9 District A2, B1, C3 2nd year = 8 Districts A1, B4, C3 3rd year = 3 Districts B3 (Rationale of selecting districts not clear).

S.No/ Name	Objectives/ Goals	Focus	Regional Distribution
7. KSAPS	• To assist state in reducing the rate of growth of HIV infection and strengthen capacity to respond to HIV / AIDS on a long term basis. This includes: - Delivering cost effective prevention against HIV / AIDS - Promotive intervention for general community. - Low cost AIDS care. - Institutional strengthening. - Intersectoral coordination.	• Selective Primary Health Care /AIDS / HIV Control - Surveillance and clinical Management. - Sentinel Surveillance - Blood safety programme. - STD control - IEC - NGO coordination - Training programmes	• 14 sentinel sites in 10 districts • 25 NGO's in 9 districts (15/25 in Bangalore) • 30 STD clinics in 21 districts.
8. RNTCP	• Detect atleast 70% of estimated incidence of smear – positive cases through quality sputum microscopy. • Administer standardized SCC under DOT during intensive phase and quality supervision during continuation phase. • Achieve 85% cure rate among all newly detected sputum positive cases.	Selective Primary Health Care including • Strengthening and reorganizing state TB control unit. • Rigorous method for detection treatment and monitoring. • Strengthening training research capacity • Targeting smear Positive cases. • SCC with DOT • Decentralizing service delivery to Periphery • Rigorous system of patient recording and Monitoring.	• Initially Bangalore Urban only Now 7 districts of Chitradurga, Bellary, Raichur, Bijapur, Mandya, Bangalore urban (excluding BCC area)

S.No/ Name	Objectives/ Goals	Focus	Regional Distribution
9. DANPCB Now NPCB-K	Reduction in the prevalence of cataract blindness from 1.4% to 0.3% by 2000 AD	- Selective Primary Health Care and Secondary care. - State Opthalmic Cell - Upgradation of Medical colleges, District hospitals, Taluk hospitals, mobile units and PHC's - Eye Bank - Training of surgeons and ophth assistants. - District Blindness control societies. - Cataract surgeries - Microplanning - IEC, MIS, SES -	Focus on all districts in all divisions. (Performance very good in Bangalore urban Udupi, Bagalkot, Dharwar, Gulbarga. Very poor in Chitradurga, Chamrajnagar, Kodagu, Gadag, Haveri, Belgaum, Bijapur, Davangere).
10. UNICEF - GOK	• To promote comprehensive and holistic survival, growth and development of children in state through - Improved new born care. - Development protection and early stimulation of vulnerable 0-3 years. - Enjoyable and quality education for pre school and primary level. - Access to clean water and sanitary environment. - Protection from child labour. - Improved Nutritional status. - Better child care practices.	- Multidimensional child health care and social development. (Primary Health care) • Community, convergent action (CCA) • Health Action • Child Development and Nutrition. • Water and Environmental Sanitation. • Education • Child Protection (Sericulture and Bonded labour) • Communication and strategic planning.	• <u>Different Districts</u> • <u>CCA</u> - Mysore, Chitradurga, Gulbarga and Raichur. • <u>Health</u> - Bidar, Raichur, Gulbarga and Bijapur. • <u>School sanitation</u> Mysore, Tumkur, Chitradurga. and Raichur • <u>Other Activities</u> In all districts

- There is overlap between projects in different areas e.g
  - IPP IX and RCH have fair degree of overlap
  - Training overlaps in many of them. (see also case study)
  - Also IEC and MIS
  - Surveillance and Health Management Systems especially since they often focus on same districts, same categories and same health centres and teams. (This will be considered again later).

5. Equity Focus

- The focus on disadvantaged or marginal groups in the community varies from explicit to ambiguous. In IPP VIII (Urban poor) and KHSDP (disadvantaged sections /ST/SC/women) it is more explicit while in all the others it is ambiguous, mostly with a sort of 'reaching all' focus. In RCH there is specific reference to 'Gender sensitivity' and in UNICEF's programmes focus on 'child labour' is emphasized, which are significant.

- In terms of addressing Regional disparities in health structures and systems in the state, EAP's have a very varied contribution

  - KfW and OPEC are specifically focussed on the disadvantaged Northern Karnataka (Gulbarga Division), though the donor decided this focus in the latter loan, not the state.

  - IPP VIII is focussed on urban poor in Bangalore being the largest urban conglomeration in the state though in the next phase other cities and towns are being covered.

  - KHSDP, KSAPS, NPCB-K focus more widely.

  - Others like IPP IX, RCH, RNTCP and UNICEF do focus selectively on some districts more than others for different components, but while the disadvantaged Northern Districts of Karnataka do get included quite often, the focus is not based on data for regional disparities or need, but seem more adhoc, responding to more extraneous pulls and pushes for selection including districts patronized by politicians or other 'lobbies' or other such non-technical reasons.

6. Local and National Agendas

- Finally except OPEC and KfW which are only Karnataka determined and focussed; and KHSDP which is Karnataka focussed but has counter parts in Punjab, West Bengal and now Orissa; all the other projects are similar to those promoted by the funding agencies in other states as well. Many like RNTCP, AIDS, NPCB-K, perhaps even RCH and IPP IX are evolved as framework /

packages at National level and then offered to the state as a 'fixed package deal'. Sometimes the state directorate and experts have tried to modify or review these national level prescriptions and tried to adapt them to state level realities but by and large this process of adaptation is rather weak and adhoc.

- However while the sense of ownership by the state was very strong in KHSDP / OPEC / IPP VIII it was relatively much less in the others and very little perhaps in RCH which showed absence of stakes in planning and formulation.

- Incidentally in IPP VIII especially in the sector of innovative schemes there are different approaches and schemes being tried out in Bangalore, Hyderabad, Delhi and Calcutta – a diversity which was both welcome and significantly different from the usual 'central top down' prescribed packages.

- Regional disparities between states and within states are so stark that greater emphasis on District level planning in the context of local socio-epidemiological evidence and situation analysis is an important policy imperative. EAP's could well be an instrument to experiment with such diversity of approaches.

Status of Bank Group Operations in India (March 31, 1999)
Original Amount with US$ (Millions)

Sl. No	Project	Fiscal year	IBRD	IDA	Cancel	Un disbursed	Develop Obj	Implemental Projects
1	Population VIII (IN-PE-9963) *	1992	-	79.00	-	55.86	S	S
2	National Leprosy Elimination (INPE-10424) *	1993	-	85.00	9.07	24.71	S	HS
3	Karnataka Water Supply and Environment Sanitation (IN-PE-10418) *	1993	-	92.00	-	31.64	S	S
4	Population (IN-PE-10457) *	1994		88.60		50.16	S	S
5	Blindness Control (IN-PE-10455) *	1994		117.80		81.38	S	S
6	State Health System II (INPE-35825) *	1996		350.00		263.11	S	S
7	Reproductive Health (IN-PE-10531) *	1997		248.30		233.16	S	S
8	Malaria Control (IN-PE-10511) *	1997		164.80		152.45	S	U
9	Tuberculosis Control (IN-PE-10473) *	1997		142.40		128.63	S	U

S – Satisfactory, U – Unsatisfactory and HS – Highly Unsatisfactory
Note: This table is not specific to Karnataka but is an overview of the All India situation. Projects which are relevant to Karnataka are shown by an asterisk.

Source: Report No. 18918-1 N Project Appraisal Document May 13 1999.

D: Overview of Programmes and Activities

- **Table III** provides an overview of the overall focus of the programmes and activities using budget headings including special programmes and allotments. About 34 components were identified of which 13 were the commonest in all the 9 projects (UNICEF was excluded in this table). These were

6 and more than 6 out of 9

- Construction;
- Furniture;
- Equipments;
- Drugs and supplies;
- Local training;
- Local Consultancies;
- Maintenance of Vehicles and Equipment;
- Contingencies.

4 and less than 6 out of 9

- Staff salaries
- Vehicles
- Management Information System (MIS)
- Information - Education - Communication (IEC)
- Project management
- NGO support.

- **Hardware over Software**

The main focus of most of these have been hardcore infrastructure development (Buildings, Equipment, Vehicles etc) and though software- like training, IEC, MIS and NGO support were included and envisaged, at the operational level, hardware always got greater focus than software. Also hardware was seen as absolute necessity so often as in IPP IX and KHSDP, constructions were focussed upon rather than initiating some of the software using locally available facilities and resources concurrently. Also hardware investment was substantial and needed greater supervision and control distracting from software development which however is probably more important if long term sustainability is to be thought off.

- **Inadequate quality improvement focus**

Another feature of the overview findings are that some elements which contribute to improving quality especially at operational or performance level were not always included in the project design and cost allotments.

These included

- Provision for books and training materials;
- Training material development;

- Innovative schemes;
- Revolving funds;
- Evaluation studies;
- Documentation.

Very few projects had them as special allotments. No doubt some may have spent on these items under other budget heads but allotment of a budget need for any programme activity is definitely a sign of priority or significance.

- **Equity focus**

Finally special focus on poor, disadvantaged and on women was mentioned in many projects but only in IPP VIII and KHSDP were their specific programmatic allotments for women orientation and involvement (IPP VIII and KHSDP) and for safety net for the disadvantaged (KHSDP). Only a special allotment can ensure that the thrust is part of operational policy.

- **Additional items**

However since there were variations in the focus of the health problems addressed by different projects specific allotments for specific additional themes were observed. These included waste handling (KHSDP); Blood safety and voluntary testing and counseling (KSAPS); Adolescent Health (RCH); School Health (NPCB-K) all very important and significant. Some elements like school as a focus of health activity should be a compulsory component of all health projects because preparing / orienting future citizens is a policy imperative.

- **Learning from previous experience and each other**

While UNICEF schemes were not included in the table their allotment to a range of themes around child health exemplified a much more holistic; practical and operational approach. The programme highlights included convergent community action; border cluster strategy for MCH and ICMI (Integrated Management of Childhood Illness); Child development and nutrition; Water and environmental sanitation; *Janashala* programme child labour protection; HIV / AIDS prevention activities, etc.

NB: It is unfortunate that UNICEF's longer experience of moving from 'biomedically defined technological approaches' to more 'holistic initiatives responding to broader socio-economic cultural realities' has been totally ignored and World Bank's 'selective prescriptions and initiatives' allowed to distort health planning and in many cases leading to a reinventing of the wheel. Dialogue between project funders and building on past experiences is crucial otherwise EAP's could be a wasteful distortion and also being 'loans' rather than 'grants' could be wastefully counter productive.

E : Overall Strengths and Weaknesses of EAP's

Table IV lists out the key strengths and weaknesses of different programmes as identified by literature review and endorsed by interactive discussions. They vary from programme to programme and cover wide range of sectors and issues.

Strengths

Taken as a composite group the key strengths of these projects are:

1. **Infrastructure development**

They have focussed primarily on infrastructure development, which includes buildings for hospitals and health centres, operation theatres, staff quarters etc. While these were necessary since the directorate had not invested in adequate maintenance of existing infrastructure nor invested in adequate construction to fill up the lacunae in the past, the demands of infrastructure often have tended to overshadow all aspects of the project.

2. **Support field action**

In the situation when programme action budgets are shrinking with salaries taking over greater and greater percentage these projects help to promote specific action components and field activities.

3. **Framework of strategy : planning capacity enhanced**

Conceptually whether primary or secondary, comprehensive or selective, many of these projects have led to generation of some framework of strategy and action and have been supported by a degree of background homework. Though the data base is often patchy it is better than some of the adhoc decisions in the past which were often repetitive without adequate evidence or data. Project formulation including setting objectives; outlining strategies; identifying action plans; identifying outcome and impact indicators and benchmarks all have helped build planning capacity even though the compartmentalization causes overlap and some distortions.

4. **Innovations**

Project autonomy, which is relative has allowed many innovations to be experimented with, which is a change from the routine generalized top down prescriptions thrust on the whole system in different districts uniformly and at all levels in the past. All the innovations cannot be listed out here but from the table some of them need to be highlighted. These are

a. Link workers (IPPVIII)
b. Women's clubs (SHE clubs) – IPP VIII
c. Gender sensitivity and women's orientation – IPP VIII

d. Herbal gardens – IPP VIII
e. Help desks and Boards of visitors – IPP VIII
f. Tribal ANM training – IPP IX
g. Partnership with NGOs to run centres, (IPP VIII, IPP IX, RCH and KSAPs)
h. Special interventions for disadvantaged – yellow card, KHSDP
i. Comprehensive MIS being evolved – KHSDP
j. Improvement of referral links - KHSDP
k. Good mechanisms for construction and supervision – KHSDP
l. Efforts at quality improvement (IPP VIII, KHSDP)
m. Focus on women specific and budget heading (KHSDP)
n. Decentralization of accounts (KfW)
o. Focus on Northern disadvantaged districts (KfW, OPEC, RCH, UNICEF)
p. Links with Literacy campaign (RCH)
q. Focus on adolescent age group (RCH)
r. Partnership with private sector – some contract services (KHSDP)
s. Involvement of Medical colleges (RCH, UNICEF)
t. Newsletters (KHSDP)

Many more may be there but these are a representative sample. However there seemed little effort at documenting these 'innovations' and even less on monitoring or evaluating them in any sort of methodical or rigorous way. It is important to ensure that they add value in quality and efficiency to the existing PHC option programme before they get adopted by the whole system as an added innovation.. This element of operational research was significantly absent.

Weaknesses

The key overall weaknesses of EAPs were

1. **Overemphasis on infrastructure**

While focus on infrastructural development was a strength as pointed out earlier, it also tended to overshadow all the so called 'software' or action / programmatic components.

2. **In house Planning Capacity not enhanced**

Many of the projects used external consultants who helped to improve project planning capacity but this did not necessarily get internalised in to the existing health system.

TABLE - IV

Externally Aided Projects in Health Service Delivery in Karnataka

SOME STRENGTHS AND WEAKNESSES

S.No/EAP	Strengths	Weaknesses
1. IPP VIII	• Comprehensive Conceptual Framework (Family Welfare, MCH, CSSM Water supply and sanitation Education, Community Development). • Involvement of Community through Link Workers, Women's clubs (SHE clubs) (Social Health and Environment) etc. • Establishing crèches, NFE and Vocational training. • Involvement of NGOs • Gender sensitivity and women orientation • Flexibility e.g. different innovative schemes in Bangalore, Calcutta, Delhi and Hyderabad. • Social paradigm awareness stronger at all levels. • Operational guidelines for most aspects of project quite good. • Some good practices: - Help desks in centres. - Herbal gardens in all - Overall morale and discipline of staff good. - Contract for cleaning / security efficient - Board of visitors. - NGO participation. • Citizens charter • Slum based centre (more accessible) • Human Resource Development.	• Focus on Family Welfare predominant other programmes present but adhoc and not adequately integrated perhaps even inconsistent. (Need to actively convert from FWC to urban Primary Health care centre). • Long term sustainability especially regularization of centre staff not adequately addressed. • Partnership and Liaison of project team with Corporation Health Centres problematic (ownership by corporation inadequate) • IEC more material preparation than field use. • Orientation and motivation of Doctors not maintained after initial training (need for more problem solving sessions) • Many innovative schemes built upon but not in a sustained way. • Involvement of NGO's and community and G Ps patchy. Not adequately evaluated or monitored. • Lab facilities and services to be improved.

S.No/EAP	Strengths	Weaknesses
2. IPP IX	• Focus on rural Primary Health care - Filling gaps. • Flexibility in project formulation and utilization across financial years without lapsing of funds. • Software inputs like IEC, Training included in project components • Innovations like - Tribal ANMs for tribal area (relaxed requirements strengthened training) - NGO take over of PHCs (two experiments) - In some activities like IEC focus on Northern Karnataka based on regional disparities has been project emphasis (at proposal level only) - Short listing of NGO's done through a planned / realistic procedure though time consuming.	• Hardware(civil works) Moved better than software. • Overall implementation delays with complacency in the initial stages and some lack of clarity/ capacity. • Ownership by District Health officers Inadequate. • Centralized implementation except for building aspects. • Operational guidelines for many aspects were not initially catered for e.g. Fund flow mechanism to ZPs. • Monitoring mechanism not adequate to support effective implementation. • Community involvement of village committees - not adequately implemented. Involvement of NGO equivocal. • Lack of continuity of key personnel in the project – handicapped the project. • IEC virtually a non-starter • Training process direction given to NIHFW (National) rather than SIFHW (State) which led to delays. • Government level decision making bureaucratic - 3 standing committees delay decision
3. KHSDP	• More than just secondary Care. Conceptually also focuses on: - Special interventions for Disadvantaged (Yellow card scheme). - Comprehensive Surveillance system - Trauma centre - Hospital Waste Management. - Blood Bank modernization. - Improvement of Referral links. • KHSDP, OPEC, KfW share capacity building initiatives. • Good mechanisms for Construction and infrastructure development has been organised that can be used by other projects as well. • Some areas of focus relevant for Quality development – Equipment maintenance, Quality, Women and disadvantaged, Drug procurement policy, Medical waste management.	• Delay in construction and civil works continue and 'local problem solving' to get over constraints not yet adequately decentralised. • Huge cost over runs affecting planning and process. Contracting out and partnerships with NGO's and others not being adequately monitored (Are the effects really better?) • Strategic planning cell has not been developed adequately at capacity level and from the point of sustainability of planning process it is adhoc, marginal. • Ownership problems especially for long term sustainability not adequately addressed. DHS or ZP who will maintain?

S.No/EAP	Strengths	Weaknesses
4. KfW	• Focus on a disadvantaged Region. • Linked to KHSDP for most of software development. • Account in Gulbarga (helped decentralised utilisation by Additional director for project stationed there. • Improve Administrative facilities at hospital level as well as for District Health officers and Taluk Medical officers. • Strengthen referral. • Additional staff. • Project conceptually includes focus on disadvantaged and women. • Epidemic preparedness.	• Only lip service for Software components (Training, referral, MIS, support services not adequately addressed inspite of availability of KHSDP support system). • Slow fund release / Utilization. • Seems mostly brick and mortar project. • Decentralised utilisation of funds without close monitoring led to problems of leakage, poor quality control, 'thoughtless payments' (Dilemma of centralization Vs decentralization) • Foreign consultants (SANI Plan) from Germany were not very effective in their coordination with local consultants hence inordinate delays. Affected by Indo - German relations. Scaled down after the nuclear bomb!
5. OPEC	• Focus on a disadvantaged region of the state (but the choice seems to have been by the donor).	• Not a comprehensive plan. Very focussed on just a hospital and not need based. • Inadequate local planning and ownership. • Delays and adhoc action. • In the planning no clarity on how to implement or actually go about running the institution. • No clarity on how government will raise minimum Rs. 10 crores per annum to run the hospital (Now approaching Private sector for partnership!) • No clarity on how tertiary, secondary input would link or support PHC through referral system. • Presently the hospital has been inaugurated and providing minimal OPD services. Plans have been initiated to find a private sector partner !

S.No/EAP	Strengths	Weaknesses
6. RCH	• Attempt to adopt Community Needs Assessment approach (in principle). • Adolescent Health priority. • Links with literacy campaign • Financial envelope idea: - Focus on disadvantaged. - States free to choose intervention. - Flexibility etc. • Focus on Northern districts - Gulbarga, Bidar, Raichur, Koppal, Bijapur, Bagalkote. • Bellary sub project which involved NGOs. • Partnerships with NGOs, Professional bodies and medical colleges initiated.	• The work of UNICEF support in the earlier phase of RCH not acknowledged. Programme not learning from earlier experience and strategies. • Civil works preoccupation like • Other WB projects with delays and cost over runs. • Software components like IEC, Training, moving very slowly or not at all. • Too much Family planning oriented not integrated with health adequately (Population agenda strong). • Delays in basic training / delivery kits etc. • Focus on Secondary care more than primary care - institutional services more than field services. • Top down Package deals oriented rather than 'process' and local planning and empowerment oriented. • Overall progress of RCH project which is high priority is very slow and financial utilization seems quite sluggish. • Nutrition neglected in programme. • Consultants not clear about actual roles. • Not adequately integrated at project planning level (left to adhoc decisions). • Too women oriented need to retain balance and involve men as well. • Sustainability not addressed Community Needs Assessment on paper.

S.No/EAP	Strengths	Weaknesses
7. UNICEF	• Complementarity of initiatives like CSSM, RCH, and immunization. • Using fixed day session and campaign approaches. • Pilot schemes tried out in some districts or towns and then expanded / replicated in other areas. • Generation of training materials and training programmes more local and relevant. • Involvement of Medical colleges, research centres in MICES survey and other projects. • Learning from experience and responding to local needs and demands good. • Policies, guidelines manuals evolved with local expertise. • Policy to focus on Northern Karnataka and districts with weakest child development indicators.	• High vacancy rates of ANMs in disadvantaged Northern districts. • Logistics of cold chain Drugs, kits not adequately tackled delays etc. • Orientation / training of Programme managers to deal with many departments network, sustain partnership is still not adequately developed. • Complementary of UNICEF and • RCH (WB) programmes not adequately tackled due to project compartmentalization. Inspite of attempts to promote inter sectorality UNICEF support programmes still get listed to one department or the other.
8. RNTCP	Very important priority problem. Hence selective strategy still required and emphasized.	• Many DTC's do not still have District TB officers (9) • Laboratory technicians posts vacant. • Abrupt transfer of trained personnel. • Some DTC's have no building (9). • Complex procurement procedures. • Lack of cooperation from medical colleges / major hospitals. • Inadequate budgetary support at state / district level. • RNTCP districts Vs short course chemotherapy districts of SCC – continuing ambiguity. • Overall TB still low priority.

S.No/EAP	Strengths	Weaknesses
9. KSAPS Phase I	• Zonal blood testing centres established. • Modernisation of Blood banks. • Surveillance centres set up (8 + 5 new) • NGO involvement good leading to development of AIDS Forum Karnataka – mostly Bangalore (includes work with sex workers, truckers and care and support for PLWHA's) • Strengthening of STD clinics. • IEC activities at many levels. • Training activities on a regular basis. • State AIDS prevention society set up.	• Supply of drugs delayed and continuity of care and treatment (due to complicated procurement procedures) • Lab diagnostic facilities for voluntary testing in all districts still inadequate. • Lack of full or sustained partnership with NGO's in other parts of Karnataka. • Lack of counseling facilities in District and major Hospitals. • Inadequate policy guidelines on HIV testing.

3. **Inadequate operational management capacity**

Overall there were inordinate delays between launch of the projects and getting operational strategies of the ground. These seemed to be lack of capacity at all levels to convert 'good project objectives' into ground level strategies. While these improved over time at the state level as seen in KHSDP, IPP IX, at the ground level i.e., the District level; the PHC level and Panchayati Raj Institutions (PRI) level these remained a weak chain in the link

4. **Maintenance of Infrastructure not built in**

Inspite of predominant infrastructure development, no planning or provision has been made for future maintenance of the developed infrastructure. The state or ZP's capacity to maintain them adequately has also not been addressed.

5. **IEC non starter**

IEC was an overall weakness – with preparation of materials often overshadowing actual efficient use in the field. Often materials did get printed / produced but logistics of distribution were not adequately planned and operational use by health workers and others at the field level were most inadequate with a few exceptions.

6. **HMIS, Monitoring and Evaluation weak**

The monitoring and evaluation of the projects seemed weak inspite of efforts at building up M and E strategies and lots of effort in some projects to evolve HMIS systems. Most of the HMIS seemed to be used only by higher levels to help the central planning process or monitor the programme. At the field level or base the quality of HMIS data was often poor since the 'collector of data' did not see himself or herself as a user of the data for their own planning purposes and was collecting it disinterestedly for someone else at a higher level.

7. **Sustaining innovative ideas was inadequate**

Many innovative ideas were being tried out but their long term integration or sustainability was not properly planned for. To begin with even their complete documentation has been inadequate. Many schemes started but were discontinued without proper evaluation; while many others were continued just for the sake of continuity without monitoring evidence of value addition, if any.
Some other issues are included in the next chapter as policy imperatives.

An Innovative Scheme

"Under an innovative scheme the IPP IX project has provided funds to the Vivekananda Trust to train girls from the tribal hamlets and post them as ANMs in those hamlets. This training is a one-year course following the government-approved ANM curriculum with an added component of tribal medicine. The training has not been recognized by the Nursing Council, and the trained tribal ANMs are working through the NGOs working in these areas. Following discussions with the MOHFW, the trained ANMs have been accepted as trainees in the ANM training centers at the completion of which they will also be eligible for employment in the non-tribal areas. An evaluation of the first batch of 40 tribal girls trained as ANMs indicated a satisfactory knowledge of MCH, herbal medicine, nutrition, and personal hygiene. However, their knowledge of the reproductive system and human anatomy needed strengthening, and this will be rectified through training in the government ANM training schools. This scheme ensures access to MCH services in the remote and underserved tribal areas, and the presence of a female service provider at the SCs. Another important benefit is the opening up of job opportunities to tribal women within and outside of the tribal areas".

Source : IPP IX World Bank Review Mission Aide Memoire

F. Lessons from Case studies

In spite of the time constraint the researchers felt that it would be a good idea to add a few case studies of the situation on the ground vis a vis some operational aspects of these EAP's. Using two strategic opportunities – a quick assessment of 'training' opportunities experienced by a group of medical officers in a Northern district was included as case study A and a surprise visit to an urban health centre covered by an EAP was included as case study B. Both case studies focus on some learning experiences from ground level realities and are not meant to be taken as any sort of rigorous evaluation.

1. Lessons from case study – A

An interview of 6 doctors in a surprise visit to a Northern district showed the quantity and quality of training inputs from a wide variety of EAP's (around five EAP's) These are described in case study A. They show the following important trends:

i. Five out of the 6 doctors had undergone some training or the other with three of them having attended 5-6 training programmes. Most of these have been in the past 5 years (1995 onwards) This has not been a uniform process with some getting more opportunities than others.
ii. The EAP's supporting these training programme included IPP IX, RCH, NACO, DAN-PCB AND CSSM (UNICEF)
iii. The programmes ranged from 4 days to 18 days.
iv. Most of them were in the Rural Health and Family welfare training centre though one was at Hubli and other at Bangalore Medical college.
v. Most of them wanted CME's atleast once or twice a year.
vi. They suggested better skill orientation in training programmes and more comprehensive induction training when they first join as PHC medical officers.
vii. Have suggested better resource persons and better centres than at present.

On the whole the case study shows that the EAP's have managed to support training of project mangers at field level even in the disadvantaged Northern districts which is very creditable. However since these are done by different project administrations there is overlap in themes and focus and the selection of courses do not fit in to any available training schedule or CME of a local PHC. The selection and deputation seems adhoc and opportunistic. Very often the MO gets transferred after a special training programme so he is not able to add value after training to his ongoing work.

CASE STUDY – A : Training Experience in Northern district

A few Doctors with Government service varying from 6 months to 20 years were interviewed regarding their training under various projects / programmes. Some details about the training of these doctors are given below:

1. Dr. A with about 7 1/2 years of government service had undergone the following training

a.	MCH Training	CSSM	1 week	1995	RHFWTC
b.	FP & MCH Training	RCH	1 week	1997	"
c.	FP Training	CSSM	2 weeks	1998	"
d.	Management Training	IPP IX	2 weeks	1999	"
e.	Administrator Training	MO Training	1 week	1999	Nauzad Ahmed, Rural Development Training Centre

Inspite of all the regular training feels necessity for skill based training in MTP, tubectomy (learnt tubectomy himself) and CME's (atleast twice a year). Also felt that quality of training at RFWTC could be improved by getting trained resource persons from private / professional institutions.

2. Dr. (Mrs.) B with about 5 1/2 years service underwent the following:

a.	CSSM Training	CSSM	-	RHFWTC
b.	Combined Medical Education	IPP IX	18 days	"
c.	Blindness Training	DANPCB	-	"
d.	Leprosy Training	-	4 days	"
e.	AIDS / STD Training	NACO	4 days	At Hubli
f.	RCH Management Training	RCH	5 days	RHFWTC

Had not been given any training in MTP or tubectomy. Felt that such skill based training would enable to cater to the female population. Felt the need for CME's (1-2 per year).

3. Dr. C with 1 year service (excluding 4 years contract service). Very capable, efficient young MO, underwent the following training:-

a.	Reorientation Training	IPP IX	2 weeks	1996	RHFWTC
b.	MCH Training	RCH	2 weeks	1997	"
c.	Leprosy Training	-	1 week	1998	"
d.	Management Training	-	1 week	2000	"
e.	STD / AIDS Training	NACO	1 week	2000	"
f.	Medico-legal Training	-	2 weeks	2000	Bangalore Medical College.

Is able to assist in tubectomy only. Feels the requirement of better training courses and skill based training in MTP and tubectomy. Also feels that he could benefit from CME's.

4. Dr. D having 6 1/2 years service has underwent only Orientation training and Management training under IPP IX. Has assisted in tubectomies. Feels the necessity for more comprehensive induction training and training in Administration and Medico-legal aspects.

5. Dr. (Mrs) E also serving in the District with 5 months service has had no training whatsoever (regular KHSDP appointment). Feels the requirement of rigorous training in all aspects to effectively perform the job responsibilities of a PHC doctor.

6. Dr. F serving in the District with 5 years Government service underwent only 3 weeks continued Medical Education Training under IPP IX on induction (1995 October) and no other training. Assists in practical training of ANM's at the co-located ANM Training Centre. Feels the requirement of regular training especially skill based and activity based training. Training needs identified include MTP, tubectomy (including laprascopic), anesthesia and Medico-legal training (including post-mortem is a must), as he has performed 30-35 autopsies in his short service.

2. **Lessons from Case Study – B:**

A visit to an urban Family Welfare (Health centre) supported by an EAP showed some interesting features described in the observations listed out in case study B.

The case study emphasizes that inspite of quite a good level of conceptual framework generation and the evolution of a large number of guidelines the gaps between concept and practice can be wide.

Various local adhoc, modifications of programmes: temporary or permanent short cuts: lack of continuing education: supportive supervision and motivation of field staff: poor logistical support to supplies: and lack of sustained efforts to maintain an innovation can lead to discontinuation of innovations; closure of certain functions; modifications of strategies which can be wasteful or counterproductive; or result in glaring mismatches and distortions as exemplified by the observations.

While some functions go on fairly well and as per the objectives, some get distorted or modified. The case study exemplifies the need for continuous monitoring and evaluation; efficient supplies and logistic support; constant problem solving supportive supervision; and good team work and continuing education to ensure the quality of the implemented programme and to reduce what is often called in policy circles 'the implementation gap'.

CASE STUDY B- An Urban Health Centre

SECTOR OF WORK	OBSERVATIONS
1. Family Planning Oriented	No male patients seen; No well baby clinic; No well women clinic; No screening for Breast Cancer or Cancer of the Cervix; Only IUD insertion carried out, CCs and OPs distributed
2. Referral Oriented	No normal deliveries conducted even in day time. All deliveries referred to Maternity Centres (MCs) Referral card not well designed and common to all categories. ANC card not given to the patient. Laparoscopic Tubectomy or Tubectomy at MCs only.
3. Laboratory services not available	Only Haemoglobinometer available cases usually referred to MCs, long queue; Tests sometimes done at UHC by visiting Lab technician's; Lab tests -VDRL Hb, Blood group, Urine Albumin.
4. Family Planning services	Only where LMO trained, only Menstrual Regulation Conditional i.e., only if patient willing for tubectomy / IUD.
5. Drugs Inadequate	Inadequate quantity to routinely treat OPD patients. Very limited antibiotics. No pediatric preparations/ syrups, no eye/ ear drops (except chloroapplicaps) or skin ointments. Definitely not Rs.50,000/- p.a. worth of drugs. LMOs give prescriptions for purchase from outside.
6. SHE clubs defunct	Earlier vocational training - now discontinued. Only serve as community feedback group.
7. Link workers a strong asset	From community, dedicated. Low honorarium so frequent turnover. Bring ANC cases early as well as children immunization.
8. LHV / ANMs from corporation	Experienced, competent (could be corrupt)?
9. Immunization	Cold chain maintained. Vaccines available. Outreach immunization also. Twice a week, so load less.
10. Health Education IEC activities discontinued.	Do not put posters in slums as destroyed by children. A-V van discontinued due to corruption. Mainly printing - less lecture demos.
11. ISO 9002 Certification	Purely technical assessment. Based on parameters like cleanliness, record keeping, waste disposal, sterilization of OT and equipment etc. Would not significantly improve quality of care. False sense of perfection.
12. Fall in activities / performance	Since start of centre all activities have reduced significantly. Assessment required of reasons for this.

Glossary IUD – Intrauterine devices
MC - Maternity Centres
OPD - Outpatients department
CC - Conventional contraceptive (Condom)
LMO – Lady Medical officer
ANC - Antenatal card
UHC – Urban Health centre
OP - Oral Pills

G : Some Policy Imperatives Including Integration and Sustainability

The previous chapters provide an overall framework of the 10 EAP's in Karnataka and some of the quantifiable or qualitatively describable indicators and features of these projects to help the project overview. As indicated in the project protocol this exercise was primarily a critical policy review and not an evaluation exercise of each of the EAP's per se. Some of the finding in the previous chapters and tables have addressed some of the questions that were included in our original list. In this chapter we try to address those which have not been adequately covered by the earlier one as well as provide some additional critical comments even on those that have been covered, drawing primarily from the very candid and frank interactive discussions we had with a wide variety of project directors. These policy issues and imperatives are as follows:

1. Scope of Projects

All the projects focus on Health System Development with varying degrees of emphasis on Primary Health care. While some focus on secondary level (e.g. KHSDP) there is a built in assumption that the secondary care support is with a view to support through efficient referral systems – the primary health care network. While in practice the links may not be so well established the conceptual framework is well directed to this issue. It is at the 'Public Health' context level however that the projects show a general weakness inspite of the fact that unlike other states in the country 'public health expertise' is available even among the senior leadership of the state. One can only surmise that in the changing financial situation perhaps financial management contingencies and bio-medically defined management framework are inadvertently distorting public health concepts and priorities. The focus on basic determinants of health is weak (nutrition, water supply, sanitation, environment) both at content level, emphasis and linkages; key public health components like surveillance and health promotion are inadequate; and the 'new public health' emphasis on empowerment of the community and public at large in health decision making is totally overshadowed by top down provision of specific packages euphemistically called social marketing. This lacunae / weakness needs to be seriously addressed.

2. Project Planning

In the absence of a strong Strategic Planning Cell in the Directorate (inspite of a provision in KHSDP for this) problems of project flexibility, design, long lead times and delays, in preparation, complications in procedures and various ongoing management and operational problems, all of which have been experienced in one EAP or another – are a symptom of lack of adequate attention to building in-house capacity for more realistic project planning and management. This has led to compartmentalized planning, inadequate collection of field based data or evidence, and adhocism in decision making further compounding the problem. Lessons are not learnt from positive and negative experiences of a particular EAP or its success

at some form of system development so the 'wheel is reinvented' each time by each project and the system is not enriched by the collective experience. E.g. Different EAP's have had different experiences of dealing with the 'NGO sector' or the private sector – some positive; some not so positive; some even disastrous in terms of unreliable partners or even 'fly by night' operators but the whole system does not learn from this to evolve a Directorates policy for NGO or Private sector partnership. This situation may change with the Task Force recommendation on state policy directives but for the present this is a lacunae to be urgently addressed.

3. **Who drives the projects?**

This was a very difficult policy issue to address. On the face of it, the State Government / State Health Directorate drives the project not the funding partners or their external consultants and all sorts of mutual consultations / reviews are organised. However two factors do affect the 'driving' of the project.

- **Absence of local homework**

In the absence of rigorous 'policy' and evidence based homework on the governments / directorate side due to a lack of strategic planning capacity as mentioned earlier, external consultants of funding partners are often able to drive the decision by just providing more options, more evidence based on data marshalled from experience elsewhere and the state policy makers are then more easily influenced or ready to accept them. e.g. During the study period an external funding agency resource person provided more data and perspective on private sector in Karnataka, than could be marshalled by local expertise thus inadvertently pushing the private sector agenda. The reliability of this data or whether it was extrapolated from quite different sources could not be commented upon, adequately without local homework.

- **Conditionalities of funding partners**

World Bank loans more than other agencies are also usually supported by some conditionalities that are clearly stated in their documents.

i. The need for economic reforms.
ii. The need to engage the private sector.
iii. The need to promote user fees as a means of cost recovery.
iv. The need to follow certain forms of 'tender' or 'consultancy 'laid down by bank' etc.

There does not seem to be adequate home work in-house on these and their implications especially long term options, before loan agreements are signed.

Some World Bank conditions

"The Country Approach Strategy (CAS) recommends focussing Bank-group financed investments on states that are undertaking economic restructuring programmes and supporting sectoral policy reforms. Karnataka is one of the state that has initiated important fiscal, sectoral and governance reforms. Further more it supports the CAS objectives by strengthening institutional capacity ....., engaging the private sector .....,

"Each project state ..... shall levy user charges in district and subdivisional hospitals in accordance with a program and time schedule acceptable to the Association(IDA)".

"Goods and works shall be procured in accordance with provisions of section I of the guidelines for procurement under IBRD loans and IDA credits" (International competitive bidding, bid packages etc).

"Consultants services shall be procured under contracts awarded in accordance with the provision of the Guidelines for the use of consultants by World Bank borrowers and by the World Bank as executing agency – published by the Bank in August 1981".

Source : Various reports of the Bank and Project Agreements

Both these factors lead to the continuing perception and the fact that indeed the 'external agent' does drive the project intentionally through general conditionalities or 'inadvertently through inadequate borrowers homework'. This needs to be addressed urgently.

Even where conditionalities are inevitable, these should be closely monitored and either reviewed if they have negative consequences or internalised into the system if they have positive implications.

4. **Are there areas of overlap / duplication ?**

- Compartmentalized projects by the very fact of being developed independently as 'stand alone' projects and not as components of a larger wholistic integrated project are bound to produce overlap and duplication.

- Not surprisingly the chairperson of the Task Force during one of his recent inspection visits found 'three operation theatres in a PHC compound' built by different EAP's with no evidence from the MIS of local needs that warranted such investment. In HMIS, IEC, and Training there are many overlaps and duplications .

- So different projects produce manuals and teaching aids or audio visual aids for Health Education which are quite similar in content;
- Health functionaries are expected to maintain a wide variety of registers that cater to the needs of different HMIS of different EAP's ; and
- Doctors go for different training programmes organised by a wide variety of EAP's that add to variety but not to a coordinated training plan at district or PHC level (see **case study A**)

- An overall integrated planning and training exercise is therefore urgently required. At the directorate / state level there are efforts to prevent this duplication of input and efforts but systematic change to streamline this process and prevent even accidental or inadvertent duplication is required since the health sector functions under a constant financial resource constraint and any effort to ensure more efficient deployment of available resources is welcome. A good example of adhoc integration is the utilization of KHSDP Resources for KfW project needs.

5. **Ownership and Leadership**

- In most projects the state level ownership is strong except perhaps in those projects which are 'package deals' decided at the centre.

- Because some of the EAP's have established independent structural identities e.g. KHSDP, IPP VIII, IPP IX, the links and feeling of shared ownership by the parent directorate (in the case of KHSDP and IPP IX) and the parent Municipal Corporation (in the case of IPP VIII) is weak. E.g. no serious consideration regarding sustainability issues and integration challenges relevant to KHSDP or IPP IX projects have been addressed at the directorate or Health secretariat. Nor is the Municipal Corporation adequately concerned about the very same issues vis a vis IPP VIII project.

- Another significant lacunae seen in the EAP's as they are presently structured, is that ownership at District level – at the point of implementation is quite weak vis a vis District Health Officers and PHC MOs; and perhaps non-existent vis a vis PRI institutions. All these three groups are crucial to ensure the integration and long term sustainability of all these projects. Ownership can be enhanced by involving all of them from the very inception and conceptual planning stage of such projects.

- Leadership of the project directors has been good as long as there have not been frequent changes of leadership or the burdening of project directors by multiple and additional responsibilities.

- However the leadership and ownership are particularly crucial if EAP's have to become more complementary or supplementary to each other and the whole

health care delivery system. Leadership that coordinates, networks and promotes linkages is crucial.

- Public Health orientation and socio-epidemiological orientation of the leadership - whether generalist administrator or medical / technical leadership is an important necessity to prevent inadvertent distortions due to extraneous lobbies or market forces. This will also enhance capacity to negotiate with external consultants and others as well.

6. **Intersectorality**

While in many EAP's the importance of this factor is mentioned, the intersectoral coordination between departments and programme managers and decision makers of different concerned ministries is still not given adequate priority. At the heart of good 'public health strategies' is the emphasis on intersectoral coordination and while EAP's may have not seized the opportunity in this aspect so far, the evolving Integrated Health, Nutrition and Population project (HNP) must focus on this aspect urgently and significantly. Even at the grassroots level a better coordination between PHC, ICDS centre, local schools, women credit cooperatives and development workers would strongly strengthen programme performance and outreach.

7. **Integration**

There is urgent need to integrate Health with Family welfare; public health , primary health care and the population agenda with each other to avoid not only duplication by compartmentalization but also to reach the community and tackle the health problems of people especially the poor in a more integrated way. Much lip service has been paid to the issue of integration but the stand alone EAP's have not tackled this issue adequately. In fact different EAP's focussed on different problems even further disintegrate the work of the directorate.

DHO's and MO's are constantly preoccupied or distracted at ground level by frequent visits of consultants, review teams, project teams asking for this and that data or feed back; the more EAP's the more such distraction from the normal planning and management routine.

At the directorate level different EAP's require different protocols to be filled, (different MIS mechanisms) so quite a bit of directorate staff time is spent in filling up questionnaires, schedules enhancing paper work but not necessarily enhancing efficiency of planning and management.

Consultants for each EAP provide their own framework of ideas and decision making. These do not allow for any inter-EAP consultant communication. One EAP may appoint a consultant that suggests one type of ideas, another EAP another type and all these have to function at the same PHC level or the same district level

or have to be operationalised by the same health functionary. This situation necessarily leads to adhocism and anarchy especially in the absence of state policy guidelines. Integration and coordinated communication is urgently required.

Another urgent area for integration to avoid wasteful duplication of time and procedure is the need for integrating all the single project related district level and state level societies into one Health society at both levels to receive and disburse the funds. Serious policy reflection also needs to be done to ensure that the District society's work under the purview of the Zilla Parishad and PRI.

8. Equity

While overall the EAP's do not have a well planned Equity focus some emphasis on Northern disadvantaged districts and on women and SC/ST have been identified and noted. HMIS of all EAP's as well as the Directorate must begin to focus on Equity in a more concerted way in the years to come. This 'equity imperative' must include

i. Geographical – Within districts and between districts.
ii. Gender – between male and female sections of the population and especially focus on girl child.
iii. Class / Caste – Between rich, middle class and poor or the so called haves and have – nots or 'landed' and 'landless' etc.
iv. Marginalisation – SC / ST or special groups such as child labour or rural migrants to urban areas, street child, elderly, people with disabilities etc.

Unless the HMIS focusses on disaggregated data the equity principle cannot be furthered by active policy or programmatic intervention. EAP's could build this in to their framework more concretely so that they go beyond policy rhetoric.

9. Partnerships

All EAP's have built some form of partnerships with the voluntary sector, NGO's, private sector, academic institutions or research institutions. But these do not build on a larger policy framework of the state since guidelines on such partnerships are not available. They tend to be some what adhoc. The directorate should actively move towards some form of Resource Directory; Accreditation system; or reviewing and registering system for such partners so that EAP's and different health departments can draw from pooled experience and pooled resource lists. A partnership cell in the Directorate like the erstwhile Society for Coordination of Voluntary Agencies (SCOVA) idea could build such directories, framework of guidelines and linkages, of use to all departments and projects.

10. Community Partnership and Empowerment

The resistance of the Health department to work with Panchayati Raj Institutions is well known and though some of the reservations of the health leadership may be

very genuine and based on difficult or awkward situations of 'interference' or extraneous push / pull factors in decision making – there is urgent need to review this and get over the problem rather than ignore it. With increasing political decentralization, PRIs will play an important part in local planning and administration in the future and EAPs should promote this process and not distort it.

The district level societies which leave decision making in the hands of the bureaucracy may be good for efficient disbursement of EAP funds but they definitely mitigate against active community participation. EAP's in particular must begin to focus on human development more than infrastructure; and in this human development component strengthening of community based organizations like PRI institutions to contribute to local planning and ensure accountability and transparency through capacity building will become as crucial as building health teams to deliver the programmes efficiently and effectively.

11. **Accountability / Transparency**

EAP's may develop their own monitoring system and evaluation systems, even audit systems but they are not accountable to the people, the political system, the legal system in the same way as the directorate and its regular programmes. While bureaucrats and technocrats may be closely involved with the development of these projects and the evolution of their frameworks of action there is still the danger of creation of a parallel system of decision making and programme management which may be seen as relevant in the short term but could become problematic in the long term.

However it was noted that overall some of the guidelines and procedures of the projects were able to immunize the project from the corruption and political interference which affect the larger system all the time since it does prevent the influence of extraneous 'push' and 'pull' factors due to clear cut guidelines that are not easy to circumvent.

In the short term review we were not able to make clear cut judgement whether extraneous interference's were making any sort of affect on programme formulation or implementation. The use of retired government personnel as consultants was common (a sort of 'old boy' network) which affected the dynamics of the programme and subsequently its performance in some cases but not necessarily to integrity. On the whole it may be surmised that EAP's are as subject to outside interference as the rest of the system not necessarily more.

However in the matter of construction costs and delays and whether some contractors were favoured rather than others – These areas were difficult to explore in the time constraint. There was hearsay evidence of this type all the time including architects inflating designs / and enhancing profit margins in other ways, etc.

12. **Sustainability**

This was one area on which there was very little real focus or policy discussion or planning in the projects at any level – project plans, project dialogue, project implementation mechanisms and so on. It is important to emphasizes that sustainability is often seen as being financial only. It is actually more than this and includes staff and other policies as well.

The overall assumptions which ignored this imperative and the trends seen were as follows:

i. The projects were seen as filling lacunae in the existing system and not creating additional structures or functions.

ii. The parent unit or department like the BMP in the case of IPP VIII and Health Directorate in the case of IPP IX, KHSDP etc were expected to take over the project when the period of the project was over. There seemed to be no contingency plans being evolved for this inevitable reality.

iii. In some project documents there was mention of cost recovery usually through user fees mechanism; or sustainability was to be made possible by NGO – or private sector partnership or take over but this was not followed up by serious operational guidelines or planning with the concerned parties.

iv. Sustainability as an issue seemed to be considered in the last year of the project as a knee-jerk reaction rather than as a serious plan evolved from the very beginning.

v. Unless the directorate estimates recurrent costs, running costs, maintenance costs and other such definable entities seriously as the time for phasing out of the project nears and unless these costs are budgeted for or recovery planned in some sort of methodical way – Sustainability like cost recovery will remain rhetorical and ultimately ignored or considered as someone else's problem at a later date.

vi. In some cases there seemed to be a confidence that some project donor would always step in to fill the lacunae if one donor phased out – so again this complacency led to a fatalistic non-planning situation which was not at all uncommon.

Sustainability of these relatively large EAP's is a very serious policy issue that needs urgent attention at the highest level and the active involvement of the finance ministry as well.

H. Some Reflections on the Financial / Economic implications of EAP's

Understanding the financial / economic implications of the increasing reliance on EAP's to support the health care delivery system in the state and the gradual shift from grant giving funding partners to becoming 'borrowers' of loans, was not an easy policy issue to review due to atleast two constraints.

- The financial management of the EAP's are separate systems not easily listed to the states own health budgeting / accounting system.
- The loan implications and the debt burden and debt servicing implications are not easy to explore in a short time constraint under which the project functioned.

The reviewers studied some earlier analysis particularly the review document (Analysis of Expenditure Medical and Public Health, Family welfare by S.Subramanya) and the more recent study of Dr.Vinod Vyasulu and group and also studied the credit agreements of various projects and the budget and account statements as well as status of project tables from World Bank and other sources. From a review of all these secondary sources of data the following conclusions and policy concerns are listed out: (See also box items which are extracts from authentic source and support our conclusions)

1. While the overall expenditure on health and family welfare is gradually decreasing and hovering between 1.1 and 1.4 of net state domestic product which is itself an overall low investment (ICSSR / ICMR recommend 8%), the reliance on EAP's is increasing which means Non-plan expenditure is coming down and Plan allocations are increasing. This is not a very healthy trend.

2. Most of the expenditure in non-plan is now directed to salaries with less and less available for programme / action components. EAP's are tending to take over more and more of this programme component – again not a healthy trend.

3. Considering that EAP's are now more and more loans rather than grants or long term soft loans this is a worrisome development. If these loans are not utilized with efficiency then we have the double burden of continuing ill health and a 'debt burden'.

4. Though all the projects talk about sustainability and cost recovery and user fees mechanism is often mentioned as a long – term option there is no indication that this mechanism is effective in reality. While some recovery has been demonstrated; and some efforts to identify those who cannot pay etc is being experimented; and the decision to let the amount / revenue collected be kept at the institutional level for local use rather than transferred to the general account or treasury – none of the mid-term reviews show that this could be a major option for sustainability even though in the short term they may help to improve quality by enhancing consumer participation. Researchers and programme evaluators are not unjustified in their concern that 'user fees' may ultimately

Health Financing – An Analysis

1. "State Finances, Health Finances and Efficiency: Three key issues, with regard to public sector finances at the state level need to be addressed. First the overall fiscal situation in many states has deteriorated sharply since the early 1990s, with a rise in the fiscal deficit, an increase in interest payments as a share of total revenues, and an increase in debt outstanding as a share of state domestic product. The deterioration in the overall financial situation faced by the states has had a deleterious effect on the health sector. The share of health and family welfare in the total state revenue budget has declined since the early 1990s suggesting that past declining trends of health sector's share in the budget has been exacerbated, rather than reversed. The decline in the health sector's share occurred despite a rise in real per capita expenditures in all states up to 1991, indicating that total government expenditures rose faster than health expenditures. Total government spending is about US$ 2-3 per capita for health services and is inadequate to meet the government's stated objectives. To achieve the government's objective of funding a basic package of health services, substantially more resources for health care are required, but the overall state finances noted above pose a serious problem. Second, within the health sector in most states, resource allocation in the public sector is skewed in favour of tertiary care services relative to needs at the primary and secondary levels, particularly rural and community hospitals. Third, much of the resources are absorbed by salary costs. The recurrent budget for operations and maintenance is chronically under-funded and the programs are not fully effective".

2. "Alternative Methods of Health Care Financing : The resource constraints faced in the health sector will required alternative methods of health care financing to supplement budgetary allocations. Alternative methods of financing health care, such as cost recovery, social and private insurance, and participatory schemes, are limited. Reported revenue data indicate that cost recovery in the health sector is about 3% on an average in India, although there are problems in estimating the level. Some of the problems faced with cost recovery include:
   a. Lack of an appropriate mechanism within the government to review user charges;
   b. Weak administrative mechanism for collecting user fees;
   c. Difficulty in targeting the poor for exemption from user fees; and
   d. Constraints to greater retention of funds generated through user charges at the point of collection.

   Based on international experience it should be noted, however, that a cost recovery rate of 15-20% in the health sector is about the most that can be expected in the public sector. In the long run, issues such as private insurance and managed health care will need to be addressed, as the industrial and urban sectors in India expand, and cost containment becomes increasingly important".

Source : Analysis of Expenditure on Medical & Public Health, Family Welfare

State Health Finances

"Non Plan expenditure, which is met from resources raised internally by the state, accounted for 63-69 percent of the total expenditure on health and family welfare between 1990-91 and 1994-95; this came down to 57 percent in 1995-96. Reduction in the proportion of non-Plan expenditure in 1995-96 is because of increase in Plan allocations and capital outlays. One reason for this increase could be the availability of funds from externally assisted population and health projects and Central government aided projects such as the AIDS control programme".

"With expenditure on health and family welfare accounting for only 1.21 percent of the net State Domestic Product down to 1.14 percent in 1991-92, but up to 1.24 percent in 1992-93, decreasing again to 1.22 percent in 1993-94 before increasing to 1.37 percent in 1994-95. It is clear that fluctuations of this nature are undesirable for the growth of the health sector as also that expenditure on health and family welfare is, by any reckoning, inadequate. A study group on Health for All, set up jointly by the Indian Council of Social Science Research and Indian Council of Medical Research, recommended 'a substantial increase in public expenditure on health at about 8 or 9 percent per year (at constant prices) over the next 20 years".

Source : Human Development in Karnataka – 1999

de-emphasize the need to focus on the marginalised. Other problems with this mechanism are highlighted in the box items as well.

5. There is a danger that increasing reliance on EAP's will ensure that programme costs in the regular non-plan health budgets will be ignored with a long – term distortion in budgeting creeping in. (This will perpetuate long standing budgetary imbalances with long term implications for health budgets).

6. There seems also a tendency to be more extravagant with issues like constructions, consultancies, equipment, vehicles, etc because EAP's promote unwittingly a more 'private sector' ethos so thrift, careful planning, basic simplicity and other such values that would ensure 'quality' at low cost or a more judicious use of resources so that more is available for grassroot needs is being affected.

7. Finally it may be important to caution that reliance on EAP's should only be a short term plan. Ultimately health budgets like the investment on education and welfare (social sector) should be increased as a long term investment in quality human development. Enough economic analysis and theory – including the more recent endorsement by the work of economists like Amartya Sen and others show this direction as the way ahead. This needs political will and commitment and some courageous state development policy planning. Let short term solutions like EAP's not come in the way of concerted, action for sustained development and higher investment in health.

J. General Policy Concerns : Are we reinventing the wheel?

The key researcher for this study and some of his colleagues had reviewed the World Bank activities in the Health Sector in India based on a case study on "The World Bank's role in the Health system in India" facilitated by the Sector and Thematics Evaluation Group of the Operations Evaluation Department of World Bank in August 1999.

That review had raised seven sets of questions / findings for a policy meeting organised by the Bank with Planning Commission, Ministry of Health and Family Welfare and others. The review of EAP's in Karnataka was a good opportunity to look at these propositions in a wider variety of project initiatives and with partnerships beyond the one with the bank. Our findings suggest that many of these concerns are very real ones even in the context of the current EAP's in the state and need to be given serious consideration by policy makers and project directors within the state before these distortions and concerns become too systemic. They are equally important for the funding partners. These concerns are enumerated as a set of policy questions that project directors and partners should reflect upon as they review their projects for long-term sustainability and integration within the larger system.

1. **Is Public Health not being adequately emphasised in problem analysis project planning and formulation?**

   - Is there a confusion in understanding public health?
   - Is economic or techno-managerial context taking precedence over socio-epidemiological analysis?
   - Are the wider determinants of health like nutrition, water supply, sanitation, and pollution not adequately addressed?
   - Is the focus on poor, indigent, marginalised not central?
   - Are regional diversities and differentials not central to decisions on focus of programme?

2. **Is Primary Health Care being given adequate emphasis and priority ?**

   - Is there focus on selective 'cost effective treatment strategies' rather than enabling / empowering processes?
   - Is there focus on first referral units rather than primary health centres, subcentres and home based care?
   - Is community involvement in planning and organisation mostly rhetorical with community capacity building made subservient to exigencies of top down management systems.
   - Are Panchayati Raj institutions generally ignored and registered societies promoted as an instrument of decentralization but under bureaucratic control?

3. **Are these partnerships adequately transparent and accountable ?**

- Are the partners willing to share the costs of failure and distortions due to poor programme design or planning which ultimately affects the poor?
- Is long term sustainability or integration into existing health care system being adequately addressed or followed up as an end of project after thought?
- Is there unhealthy competition between projects rather then collaboration and sharing of expertise and experience?
- Are accountability and transparency systems not clearly defined and hence not actively monitored?

4. **Some ethical issues and dilemmas ?**

- What is the ethics of promoting NGO-private sector partnership in the absence of solid evidence that these are more efficient operational options?
- What is the ethics of taking credit when an initiative is successful and yield positive results while pointing a finger to the directorate or ministry when the initiative is problematic?
- What is the ethics of expanding quality at the cost of or absence of adequate and operational quality control?
- What is the ethics of promoting infrastructure and 'hardware' at the cost of 'software ' that can more easily focus and reach the poor?

5. **Some management issues and dilemmas?**

In spite of marshalling lots of expertise both local and foreign is there a tendency to:

- Develop 'hardware' rather than 'software'?
- Expect 'training' to get over needs for serious management reforms?
- Little thought to social accountability and transparency?
- Inadequate attention to building ownership among different stake holders particularly district level players?
- Focussing on 'user fees' as the only primary fund enhancing option rather than looking at diverse options?
- Overall neglect of health human power issues like continuity, skill development and promoting team concept?

6 **Is the political economy adequately addressed?**

- Are the health projects adequately located in a broader, political, social, institutional analysis and adequately based on evidence of how projects run or do not run?

- Are issues such as political will; corruption and influence of lobbies political interference; market economy; being given adequate emphasis in the strategic planning exercises?
- Without developing a strong 'public health policy resource group' within the directorate is the free lancing, free floating, adhoc Consultancies and commissioned studies not allowing the means of change to become systemic?

7. **Is cultural context being disregarded?**

- Inspite of a rich and diverse tradition of Indian and alternative systems of medicine, including promotion and investment in health humanpower development in these systems by government and private initiative; are the EAP's ignoring the local cultural context and these alternatives in their formulation?

All these issues are relevant today and it was surprising to find that most of them were applicable to all the EAPs in the state and not only for those supported by World Bank. However it must be noted that the current health leadership both bureaucratic and technocratic seemed much more alive to these policy issues. That was a positive finding, symbolizing future potential. However as was brought out again and again in the interactive discussions **local holistic problem analysis and policy homework was inadequate in all these aspects. Strengthening of strategic policy analysis and development was an urgent action imperative. Policy makers and project managers need urgent orientation to Public Health aspects of decision making and socio-economic politico - cultural aspects of health situation analysis.** Any strategic planning exercise in the future for the continuation of the existing projects or the evolution of newer one must take these crucial questions into account so that the projects can be implemented more effectively and in a more realistic context with reduction in the implementation gaps.

J. Final Conclusion and Recommendations from a future Policy point of view.

The previous sections highlight the key findings and trends that emerged from the review process. However taken as a whole set of project experiences the key issues and conclusions that have emerged as significant for a concerted policy response are the following :-

1. While the EAP's do focus on a large number of health problems and health sector development issues, addressing various lacunae in the existing Health care delivery system in the state at both primary and secondary level, **they do evolve, exist and function in relatively compartmentalized ways without fitting cogently into a comprehensive, integrated strategic larger state health policy / plan evidenced by -**

- The absence of any state health policy document that includes serious reviews or details of all of them.

- Any coordinating mechanism at directorate level that addresses them in a collective context.

- Any consistent and rigorous strategic planning exercise / document that was used by programme designers when these EAPs were evolved. Some congruence / complementarity between / across projects has evolved since the members of the project committees overlap with senior policy makers common to all, but this is 'adhoc' and not always intentional.

  [Probably the HDR Report, Karnataka Task Force in Health and the recently evolving HNP project are fore-runners for this much needed paradigm shift from selective compartmentalized programme planning to more comprehensive integrated Health sector planning processes].

2. On the other hand while **compartmentalized evolution** may have lead to some problems of duplication and integration, especially in IEC and training, but also sometimes in infrastructure development, the very feature of compartmentalization has also lead to a certain degree of project autonomy that has lead to many interesting initiatives and innovations in structure, framework, operational mechanisms, evaluation and monitoring, some of which have been identified by this short-term review. These need to be rigorously documented, objectively evaluated further and adopted / adapted by the whole system as the projects phase out and get taken over and integrated by the ongoing larger systems.

3. Overall the **Directorate / EAP's have shown**

- An ability to evolve laudable objectives for each EAP.

- General lack of competence in the evidence based homework required to translate objectives into implementable strategies leading to delays in starting up times.

- Diffidence in guidelines and systems development leading to operational and execution delays.

- While ability to handle the hardware (infrastructure construction - civil works, equipment and transport) has been established, effective software development (training, IEC and Quality Assurance) has remained a weak skill / capacity. Also cost over runs have been many compounded with poor utilisation in other areas showing in-different financial management capacity as well.

4. Like the general health care services development, the projects have not shown any **evidence-based focus on equity, gender, regional disparity or other policy imperatives like impact assessment, community partnership and ownership, partnership building and decentralization** and hence though there are some successes and some failures as well, in none of these areas can EAP's be shown to have used their own programme / project autonomy to enhance the **health sector** experience in these areas. This is partly a reflection also that at the Ministry level there are no clearly circulated policies or programme guidelines on these policy imperatives and hence project managers have had to explore these dimensions if at all with diffidence rather than confidence and clarity. Similarly the issues of corruption, political interference, transparency and accountability seem to effect them just as much as they affect the larger public health system- no less, no more though perhaps in the tendering / purchase policies sometimes as conditionalities of the funding agencies, there seems to be an overall feeling among programme managers that outside or local interference is less!

5. **Lack of continuity of key personnel** has been an important handicap and lack of systems to monitor quality of care and responsiveness to local needs had handicapped the establishing or the enhancement of effectiveness. In addition selection of consultants and senior project consultant need to be critically reviewed and made more competence based and transparent. Apart from an old-boy network phenomena selection is not always focussed on skills for the job.

6. While the general impression of the programme managers seemed to be that these EAPs were not consciously **donor driven** and there was space and opportunity for local technical opinion to evolve project formulation, the impression of donor driven agenda was often attributed to lack of local homework and evidence generation and hence a tendency to accept the suggestions / frame work / ideas of working external consultants as an easy option. This aspect again underlines the urgent need to develop and enhance the strategic planning capacities of the Ministry / Directorate and making it multi-disciplinary as well [The KfW and OPEC experiences have however been good examples of the need 'to look at gift horses in the mouth' seriously which could have avoided all the problems that have followed. They have also shown the absence of long term planning capacities especially in **human resource development** for the hospitals being upgraded].

7. **Integration** as an issue does not seem to have been seriously considered by any of the projects since many projects were seen as stand alone or focusing on infrastructure not process. [The absence of clarity in development of a **referral system** complex between primary and secondary care (for example: IPP VIII, IPP IX and KHSDP) is a case in point. Similarly IPP VIII, IPP IX and RCH could have been more complementary, etc.] This leads to wasteful duplication at the ground - level.

8. **Sustainability** is another policy imperative that does not seem to have been taken seriously by the whole system since in many ways this should be a long term concern of the Directorate and not just of the EAPs. KfW project had some serious options outlined in the project part which were not adequately experimented with. [Efforts to evolve systems of user fees; efforts to identify and hand-over (contract) out services to NGO's and or private sector etc. are being experimented with in KHSDP, IPP VIII, RCH but these experiments seem adhoc and not within a clear-cut policy framework. Nor are they being evaluated objectively to establish relevance or effectivity]. Overall the human power development experience that is crucial for sustainability has often been ignored or inadequately addressed.

9. Overall EAPs do not seem to be adequately drawing upon the **Public Health / Community Medicine capacities** of the state in any concerted or formal way nor for that matter on the phenomenal inter-disciplinary capacities of institutions such as IIM, ISEC, NLSUI and other resource centers of health, social development or strategic planning expertise- many of which are also available in other districts and regions. In fact there seems to be an **overall lack of public health / sociological orientation in problem identification, situation analysis or programme planning** in the EAPs evidenced by a sense the researchers got of the dominance of :

    - Infrastructure over human resource development.
    - Bio medicine over socio-epidemiology.

- Secondary care over primary health care (especially preventive public health).
- Centralization over decentralization.
- Provision of services over enabling / empowerment strategies.

10. Finally a **review of EAPs** undertaken by us, inspite of the time and methodological constraints, lead us to suggest that there is urgent need to:-

a) ***Develop strategic planning capacities in the Health sector of the State to handle the complexities of Health sector development as well as the challenges of negotiating sustainable projects with external agencies and funding partners that develop not distort / enhance capacities all round / and integrate not disintegrate.***

This capacity should be multi-disciplinary, directorate-based and as an immediate starting point should also become the integrated evidence based monitoring unit for all the health programmes of the state including EAPs.

b) ***Develop mechanisms of integrated planning that would start as a first step of all programme managers and programme implementers being networked into a coordinated planning mechanism that from time to time focuses on integration and sustainability issues*** beyond the dynamics of compartmentalized projects / program. [The project preparatory committee of the current HNP project could well become the starting point of such a mechanism].

c) ***Both these mechanisms should draw on multidisciplinary professional expertise in the state especially public health and the behavioral sciences*** from all the resource centres both public, NGO, private and the professional colleges. (The HNP project is trying to do this by involving a multi disciplinary group like Community Health Cell (an NGO) but this needs to be done with greater clarity and flexibility.

c) ***A more detailed internal review and analysis of current EAPs should be undertaken as an in-house exercise by both (a) and (b) supported by (c) so that the positive lessons from EAP experience is integrated into health sector development in the state and distortions / problems handled by a more decentralized programme implementation mechanism or countered through more effective evidence based long term strategic programme planning.***

K. Limitations of the Review Exercise

- The task of reviewing ten Externally aided projects in Health in the state in a short term framework of 4-5 months was a very stupendous and exhaustive task and perhaps quite unrealistic as well.

- Hundreds of pages of reports, reviews and other documents had to be perused and interactive interviews had to be arranged with a large number of very busy government officials and project managers within this short term framework by researchers who also had to work within a framework of complementary demand and deadlines.

- In two cases RNTCP and KSAPS interactive discussions with programme directors could not be completed so we used reported information monthly - both presentations at KTFH meetings and documents and one other programme due to time constraint. NLEP (Leprosy control) was not included. Since this review was trying to identify the broader policy issues relevant to Externally aided projects in general all the nitty gritty's of all the projects were not focussed upon.

- The study was also focussing on many issues that are neither easy to measure nor always easy to elicit because qualitative judgements on qualitative issues are often not easy to collect especially if the judgements are negative or critical. We must record however that most of the people interviewed showed a phenomenal degree of openness, frankness and willingness to discuss even 'sensitive' areas and this candidness is really appreciated.

- We have tried to do our best integrating the rich, response and feedback that was received in the interactive discussions supported by background notes and papers and our own reading and critical analysis of all the documents that we were able to access. The effort has been made to make this review a learning experience as a partner not as a critical external reviewer.

- We hope we have been able to collate and highlight the salient features – both strengths and weaknesses of EAP's when taken collectively. Much more needs to be done to address all the questions originally listed out, some have been answered, others only just considered. More time would definitely have helped. However the experience has shown that full justification can only be done if this review, both in-house and external becomes part of the ongoing Strategic Planning Cell of the Directorate / Ministry. If our study has helped to get this message across we would have felt fully complimented by our efforts.

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Dr. Ravi Narayan,
Community Health Adviser,
Community Health Cell,
Bangalore.

Dr. Sampath.K.Krishnan,
Policy Fellow &
Research Associate,
Community Health Cell,
Bangalore.

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M. Bibliography

(This is a partial bibliography which includes the main document / reports. It doesn't include all the aide Memoir's, review mission notes, newsletters, credit agreements, project partnership documents, submissions by project directors and other formal and informal documents).

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TABLE III
Externally Aided Projects in Health Service Delivery in Karnataka
COMPONENTS OF PROJECT PROGRAMMES AND ACTIVITIES FOCUS
(Review of Budget Headings)

Sl No	Component	IPP-8	IPP-9	KHSDP	KfW	OPEC	RCH	KSAPS	RNTCP	NPCB-K	Score
1	Land Purchase / prepn	+				+					2
2	Construction	+	+	+	+	+	+		+		7
3	Furniture / Equipment	+	+	+	+	+	+	+	+	+	9
4	Drugs and supplies	+		+	+		+	+	+		6
5	Vehicles	+	+		+		+		+		5
6	Training (Local)	+		+	+		+	+	+	+	7
7	Consultancy (Local)	+	+		+	+	+		+		6
8	Training (Foreign)	+	+								2
9	Consultancy (Foreign)	+									1
10	Books / Training Mtrls	+	+								2
11	Innovative schemes	+	+								2
12	Additional staff-salaries	+					+	+	+		4
13	IEC Materials prodn		+				+	+	+	+	5
14	Revolving Fund		+								1
15	Maint Vehicles & Eqpt	+	+	+	+				+		5
16	Training Material		+							+	2
17	Evaluation studies		+						+		2
18	Kits		+			+					2
19	Video / Media		+								1
20	Waste Handling			+							1
21	Surveillance			+				+			2
22	Safety Net for Disadvan			+							1
23	Improving women health	+		+							2
24	MIS		+	+			+		+		4
25	Design and Engineering				+						1
26	Project Management	+	+	+	+						4
27	Sustainability				+						1
28	Contingencies	+	+	+	+	+				+	6
29	NGO support	+					+	+	+	+	5
30	Blood safety							+			1
31	Voluntary testing							+			1
32	Adolescent Health						+				1
33	Remunerations									+	1
34	School Health									+	1

APPENDIX - I

Project Proposal

Review of externally Aided Projects in the context of their integration into the Health Services Delivery in Karnataka.

Content List

Submitted by

Dr. Ravi Narayan, M.D. (AIIMS), D.T.P.H, (London), D.I.H. (U.K.)
Community Health Adviser
Community Health Cell
367, 'Srinivasa Nilaya', Jakkasandra Ist Main,
Koramangala Ist Block, Bangalore - 560 034.
Tel / Fax: 5525372
Email: sochara@vsnl.com

1. Introduction

Since mid 1990's, Karnataka Government has negotiated and received grants / loans from International Funding Agencies for an increasing number of Health related projects. These have included IPP - 8, IPP-9, KHSDP, KFW, RCH, Prevention of Blindness, RNTCP and other projects. These externally aided projects have their particular focus and framework and operational strategies to support and enhance both quantitatively and qualitatively different aspects of the Health Sector development. Each of them has had various mid term and concurrent reviews and some of them are currently reaching the end of specific phases. The Karnataka Task Force in Health while reviewing these projects informally in their discussions and deliberations have raised some important questions for review.

i. "What are the learning points from each of these projects"
ii. How can they be integrated into the health system incorporating beneficial points and avoiding distortions?
iii. What are the issues for consideration of sustainability, accountability and transparency" (1)

This project proposal is a short-term initiative to explore some of these issues qualitatively as a preliminary to perhaps a larger study at a later date.

Community Health Cell is a technical Community Health and Public Health oriented policy research and training group that has reviewed external aided projects in the past. Four policy initiatives are relevant to this study.

1) Review of health projects in India supported by Misereor / Germany. (7)
2) Review of Health Partnership of Memisa in Netherlands. (6)
3) Review of partnership in Health (Cebemor Netherlands Government) (5)
4) Policy reflections on World Bank Activities in India - (see references) (3)

2. Objectives of Study

1. The study will review all the externally aided projects not just individually but in their collective context and relation to the Primary Health Care and Public Health system development in the state using a SWOT approach.
   More specifically it will look at
   a. The ***Strengths*** of each project and the positive learning experiences.
   b. The ***Weaknesses*** or difficulties encountered in each project.
   c. The ***Opportunities*** that have been created or exist to enhance primary and public health care system development in the state.
   d. The ***Threats*** or distortions that may have been inadvertently caused by the project assistance to the health sector or that may be caused during the process of integration.

Some specific questions are in Appendix one, though a more structured approach will emerge after the literature, review.

3. Methodology

The time frame work of three months is too short to evolve a rigorous data based, quantitative approach to project design and therefore a more qualitative approach that will focus on a participation, interactive process is being suggested rather than an expert external review the method suggested will try to make it a collective learning experience for all concerned. Each project will be requested to allot atleast one project staff to be part of an evidence collecting, evidence sifting; and evidence collecting exercise.

The steps of the process will be

A. Phase one 15th September - 15th October 2000

i. Literature Review of all project proposals and mid term/ concurrent reviews and aide memoirs.
ii. Informal discussions with all project leaders and support team to clarify the nature and process of review and seek required support and participation (As a half day interactive workshop together, tentative date 10th October 2000.)

B. Phase Two - 15th October - 30th November 2000

i. Qualitative interviews with Directors and staff of each of these projects and with a small representative sample of other stake holders including medical officers and other staff. (Some visits outside Bangalore will be required)
ii. Interactive participation workshop with representatives of all the projects to address the issues of sustainability accountability etc. and all those issues, which are common to all projects and derive from phase one review. (atleast two, to be discussed at A. ii)
iii. A questionnaire survey of some key aspects relevant to the study to be filled up by each project as 'evidence contribution' to the review.

C. Phase Three – 15th November - 15th December 2000

i. Integration of all the data/evidence from phase one and phase two processes into a project analysis document.
ii. Circulation of this document to all concerned with a weeks time framework for replies.
iii. Incorporation of all comments / suggestions and final editing of a document to be submitted to KTFH hopefully not later than 15th October 2000.

4. Budget

A budget proposal to support the study and including costs of Researchers, other assistance, office support including photocopying, computer facilities, postage, stationery, travel of research assistant and co-ordinator of study and some supportive costs for three interactive workshops is included in Appendix Two.

The study will be undertaken by Dr. Ravi Narayan of CHC supported by a full time research associate for 3 months and drawing upon short-term research assistance from some other members of CHC team on a flexi-time basis.
Some elements of the study / review are complementary to the project proposals of Mr. Vinod Vyasulu of Centre for Budget and Policy Studies, Dr. Ramesh Kanbargi of ISEC; Mr. As. Mohamed of SJMC and Dr. Pankaj Mehta of Manipal Hospital and so their involvement in some aspects of the study will be operationalised through informal interaction at no additional cost.

Finally to make the short term process more cost effective and efficient under the circumstances - close co-ordination with the project leaders will be established so that some aspects of the study including the interactive aspects can be linked to any ongoing schedule of meeting/training programmes or midterm/concurrent reviews so that opportunity costs are enhanced.

5. Project Outcome

A project report highlighting a SWOT review of the External Aided Projects and Policy guidelines for integration, sustainability and future projects of this type.

6. References

1. Topics for Action Research Studies identified by Task Force (a KTFH handout)

2. Comprehensive Health, Nutrition and Population services development initiative in Karnataka (An idea draft from CHC)

3. Comments on Case Study of World Bank Activities in the Health Sector in India (A CHC policy reflection)

4. A Guide to sector-wide approaches for Health development - concepts, issues and working arrangements (Andrew Cassels) A WHO/DANIDA/DFID publication.

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APPENDIX - II

Integration of Externally Aided Projects in Health Services Delivery *(Karnataka)*

Some Issues and Questions to be addressed in the Review Project by Literature Review and Interactive discussions.

A Check List

1. Descriptions of each project including year of starting, period, focus, objectives, components, programmes, budgets, reviews, etc.

2. Was the 'problem analysis' and the 'problem solution' comprehensive or selective? If selective then factors used for prioritization? or selection of strategies?

3. How does the project support,
   a) Health System Development ?
   b) Primary Health Care?
   c) Public Health?

4. How is the project funded?
   a) Direct or indirect
   b) Loan agreement/conditionality
   c) Repayment
   d) Budget components etc.

5. What has been the experience of
   a) financial management
   b) disbursement
   c) expenditure
   d) delays
   e) shortfalls, etc.

6. Is the project funding leading to distortions in spending priorities?

7. Are a reliance on projects perpetuating long-standing budgetary imbalances; implications on existing state health budget etc.?

8. Are there diversities in accounting/auditing procedures?

9. Strengths, Weaknesses, Opportunities, Threats of each project including those identified by mid-term reviews.

10. Are there problems of
    a) Project flexibility
    b) Overdesigned
    c) unnecessary long lead time, preparation delays
    d) Slow rates of disbursement
    e) Complicated procedures
    f) Any other managerial/operational problems.

11. Are there areas of overlap / duplication with other projects?
    a) HMIS
    b) IEC
    c) Training
    d) Staffing
    e) Others

12. Are projects creating islands of excellence in an otherwise under funded sector?

13. Who drives the project?
    a) State Health Directorate
    b) Funding partners
    c) External consultants
    d) Others

14. Are there problems of :
    i) Ownership
    ii) Leadership
    iii) Intersectorality
    iv) Implementation
    v) Monitoring and Evaluation
    vi) Any other areas

15. How do the projects perform in the context of some policy imperatives:
    a) Equity
    b) Gender sensitivity
    c) Regional disparties
    d) Partnerships
        i. NGOs
        ii. Private sector
        iii. Academics-Research
        iv. Others
    e) Accountability including corruption and political interference
    f) Community involvement and partnership
    g) Decentralization and Panchayatiraj

16. Do multiple projects make it difficult for the government to develop and implement a coherent health policy for the health sector as a whole?

17. What has the project done in the context of sustainability?

18. Any other cross cutting themes that emerge in the discussion between researchers and the project leaderships.