



GOVERNMENT OF KARNATAKA

# NATIONAL RURAL HEALTH MISSION



## PROGRAMME IMPLEMENTATION PLAN FOR 2010-2011



**Vidhana Soudha**

**DEPARTMENT OF HEALTH AND FAMILY WELFARE SERVICES**



GOVERNMENT OF KARNATAKA

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### **Foreword**

*National Rural Health Mission has helped the State to improve upon its health parameters in terms of bringing down maternal and infant deaths, and increase number of institutional deliveries over the last 5 years of its implementation. The services provided through various schemes like JSY, Madilu (post natal kit for nursing mother), Suvarna Arogya Chaitanya,, Arogya Kavacha and so on exclusively or jointly supported by NRHM has percolated well with the rural mass.*

*The state has had an opportunity to improve its infrastructure, man power through recruitments on contract at various levels and enhanced skill development through capacity building. In its endeavour to provide improved health care facilities especially in the area of mother and child care the State with the financial support from NRHM is gradually upgrading its facilities (convert PHCs into 24 x 7 and CHCs to FRUs in phased manner.*

*During 2010-11 we would focus on 7 districts of Bellary, Bidar, Chamarajnagar, Chidradurga, Raichur, Davanagere and Kolar, identified as high focused districts with special schemes to improve the health status of the vulnerable population. And also we plan to strengthen Monthly Health and Nutrition Days, Family welfare, Adolescent and Sexual health programmes and Revised National Tuberculosis Control Programme.*

*With the support of grass root functionaries from ASHA, ANM to Managers of the NRHM programme, I hope our State will meet the expectations of the rural population through improved health care delivery system.*

*I take this opportunity to thank the Government of India for its support and guidance in this regard.*

Dr. E.V.Ramana Reddy

## *Acknowledgement*

*I take this opportunity to express my gratitude to Minister for Health and Family Welfare, GoK, for continuous support in implementation of the NRHM programme in the State.*

*Secretary for Health and Family Welfare department has always been a guiding force to NRHM team both at district and state in implementing the programme.*

*I thank Commissioner, H&FW, Project Director, KSAPS, Director, H&FWS, Director, SIHFW, Director, AYUSH, Regional Director, GoI, Project Directors-RCH & IDSP, Joint Directors heading National Disease Control Programme Divisions, Joint Directors and Deputy Directors in charge of NRHM programmes and KHSDRP, District Nodal officers, Deputy Commissioners and CEOs of all districts, District Health and Family Welfare Officers, all programme officers at district level, Chief Finance Officer and his team, Chief Administrator and his team (SPMU, DPMU & BPMU) in the NRHM wing for their tremendous contribution in preparation of this NRHM PIP.*

*I also thank team leader and members of core committee and technical committee formed to prepare the PIP for the year 2010-11. I thank all ministerial staff, computer operators and all those involved in the PIP preparation activities*

*Lastly I thank GOI for the support extended by guiding us in bringing out an implementable action plan for the year 2010-11.*

***Mr. S. Selva Kumar***  
***Mission Director (NRHM)***

# KARNATAKA MAP



## EXECUTIVE SUMMARY

The Government of Karnataka is committed to improve the health status of its population with strong focus on improving health outcomes especially among women, children and vulnerable populations such as Scheduled castes, Scheduled tribes and tribal groups. The Karnataka state health policy also provides a framework for realizing this vision. The State has constituted specific strategies and actions required for achieving the goals set under NRHM in its State Health Action Plan. The Activities proposed to be undertaken under various programmes are based on the district specific need, such as special focus on backward districts identified as C category districts and high focused districts based on prevalence of the health problem in a given area. Improving infrastructure, manpower strengthening, timely distribution of drugs and equipments needed for health care. Incentive schemes which are state specific like *Thayi Bhgya*, *Prasuthi Araiike*, *Madilu* in addition to GOIs *Janani Suraksha Yojana* are being implemented in the state to motivate women and children from weaker sections to get improved health care facilities. Programme management, Flexible financing, and capacity building of members of VHSCs, HMIS, M&E, and scope for wider community participation through intersectoral convergence have been given more importance.

The programme implementation plan gives a brief introduction to the health status in the state, background information about the state, followed by situational analysis both in terms of infrastructure and health indicators as assessed by different studies. The plan highlights the goals, objectives, strategies and activities drawn up to meet the goals under each programme. It also explains the priorities, constraints and actions to overcome the constraints as envisaged in the district action plans.

Hitherto experiences and progress with regard to implementation of various programmes like RCH-I and RCH-II during 05- 07, IDSP, RNTCP, NBCP, NLEP etc have been included in the PIP.

1. Infrastructure strengthening which includes of buildings for various facilities proposed to be undertaken under NRHM, State Sector and KHSDRP has been included in the PIP.
2. . Part A of NRHM that is RCH-II programme is detailed in the chapter 6. The main focus is to achieve the set goals with regard to MMR, IMR, TFR. These goals are slightly modified into achievable ones. Interventions related to MCH, ARSH & Family Welfare have been backed by new strategies like institutional strengthening, manpower development, capacity building, incentives to beneficiaries under different schemes, like *Chiranjeevi Yojana*, *Madilu*, *Prasuthi Araiike* (post natal assistance for SC/ST mothers belonging to BPL families - State initiative), *JSY*

with special focus on vulnerable population. Providing better health care services to the rural community is the main agenda. This is planned through making PHCs 24x7, and up-gradation of CHCs, to IPHS standards. IMNCI (HBNCI & FBNCI) takes care of critical care needed in the neo natal period. Adolescents especially vulnerable population ie. Tribals, SCs/STs, and out of school children will be given Adolescent health care services through Teen clinics which will be established in the CHCs and will be implemented in all the districts during the current year. Special emphasis is laid on male participation in the family welfare activities. Family planning programme will be intensified with special emphasis on NSV. Forming separate cell to monitor and supervise the implementation of PNDT Act in the state will strengthen provisions of PC&PNDT Act. Quality Assurance programme will be continued six districts in the state with extension to 6 more during 2010-11.

3. Chapter – 21 contains a brief note on New Interventions under NRHM like upgradation of CHCs, to provide EmOC services for mothers and newborn care to children. 23,026 VHSCs are functioning in the State and their functioning will be strengthened through capacity building of the members of VHSCs. Modules for training is developed. Untied grants for SCs, PHCs and CHCs and maintenance grants for these facilities are provided. Arogya Raksha Samitis are formed in the DHs, CHCs and PHCs in the state. Functioning of ASHAs is highlighted.
4. . Part C of NRHM ie. Immunisation programme is narrated in the Chapter 24. The state goal of achieving 100% coverage will be ensured through interventions like alternate vaccine delivery system, strengthening services in the un-served and under-served areas, involving social mobilization, mobility support to DIOs etc. Routine Immunization will be strengthened and regular out reach sessions are planned.
5. Part D explains various National Disease control programmes like Integrated Disease Surveillance Programme, National Blindness Control Programme, National Vector Bourne Disease Control Programme, National Iodine Deficiency Disorders Control Programme, Revised National Tuberculosis Control Programme, National Programme on Prevention and Control of Deafness and National Leprosy Elimination Programme.- Chapter 25.
6. . Part E deals with Inter-sectoral convergence in the chapter –34. This explains the various activities chalked out at grass root level for the PRIs role in the VH&SCs, ARS, and selection of ASHAs etc. Merger of programmes of RDPR, Education, WCD departments will be ensured through inter sectoral convergence.
7. The state PIP focuses on Innovations like: Blood line, Special programmes for vulnerable groups and School health programme is covered under Arogya Chaitanya programme. Health check up will be done for children studying in government and aided schools. It is proposed to help those children who need corrective tertiary surgeries, under Suvarna Arogya Chaitanya programme.
8. GOI approved Budget under NRHM is given in the Chapter 40.

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# CHAPTER 1

## INTRODUCTION

1. Karnataka state is one of the pioneer states in the country in providing comprehensive public health services to its people. Even before the concept of Primary Health Centers was conceived by the Government of India, the state had already made a beginning in establishing a number of primary health centres for providing comprehensive Health Care, and a delivery system consisting of curative, preventive and rehabilitative health care, to the people of the state.

### STATE PROFILE:

2. There are 30 districts in the state of Karnataka viz Bagalkote, Bangalore Rural, Bangalore Urban, Belgaum, Bellary, Bidar, Bijapur, Chamarajanagar, Chikkaballapur, Chikkamagaluru, Chitradurga, Dakshina Kannada, Davanagere, Dharwad, Gadag, Gulbarga, Yadgir, Hassan, Haveri, Kodagu, Kolar, Koppal, Mandya, Mysore, Raichur, Ramanagara, Shimoga, Tumkur, Udupi and Uttara Kannada. Each district is governed by a Deputy Commissioner or District Magistrate. The districts are further divided into sub-divisions, which are governed by sub-divisional magistrates; sub-divisions comprise blocks (talukas) containing panchayats (village councils) and town municipalities.
3. As per the 2001 census, Karnataka's six largest cities sorted in order of decreasing population are, Bangalore, Hubli-Dharwad, Mysore, Gulbarga, Belgaum and Mangalore. Bangalore is the only city with a population of more than one million. Bangalore Urban and Belgaum are the most populous districts, each of them having a population of more than 5 million. Gadag, Chamarajanagar and Kodagu districts have a population of less than one million.

### HISTORY:

4. After India's independence, the Maharaja, Jayachamarajendra Wodeyar, allowed his kingdom's accession to India. In 1950, Mysore became an Indian state of the same name; the former Maharaja served as its *Rajpramukh* (head of state) until 1975. Following the long-standing demand of the integration Movement, Kodagu and Kannada speaking regions from the adjoining states of Madras, Hyderabad and Bombay were incorporated into the Mysore state, under the States Reorganization Act of 1956. The thus expanded state was renamed Karnataka, seventeen years later, in year 1973.

## GEOGRAPHY

### Diagram-1



Jog Falls are the highest plunge waterfalls in India, formed by Sharavathi River.

5. The state has three principal geographical zones: the coastal region, the hilly Malenadu region comprising the Western Ghats and the Bayaluseeme region comprising the plains of the Deccan plateau. The bulk of the state is in the Bayaluseeme region, the northern part of which is the second largest arid region in India. Some of the important rivers in Karnataka are Kaveri, Tungabhadra, Krishna, Malaprabha and the Sharavathi.

**6. Demographics of Karnataka** According to the 2001 census of India, the total population of Karnataka is 52,850,562, of which 26,898,918 (50.89%) are male and 25,951,644 (49.11%) are female, or 1000 males for every 964 females. This represents a 17.25% increase over the population in 1991. The population density is 275.6 per km<sup>2</sup> and 33.98% of the people live in urban areas. The literacy rate is 66.6% with 76.1% of males and 56.9% of females being literate. 83% of the population are Hindu, 11% Muslim, 4% Christian, 0.78% Jains, 0.73% Buddhist, and with the remainder belonging to others.

7. Kannada is the official language of Karnataka and spoken as a native language by about 64.75% of the people. Other linguistic minorities in the state as of 1991 are Urdu (9.72%), Telugu (8.34%), Tamil (5.46%), Marathi (3.95%), Tulu (3.38%), Hindi (1.87%), Konkani (1.78%), Malayalam (1.69%) and Kodava (0.25%).

**Tabel -1 Demographic indicators**

Sl.No	India/ State	Populatio n (in '000)	Annual Growth Rate (%) 1991- 2001	Literacy Rate % Female (7 Yrs & above )	Sex Ratio (No. of females per 1000 males)	Mean age at effective marriage (females) 2007	Couple Protection Rate by all methods(%)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
<b>1</b>	<b>INDIA</b>	<b>1,028,6 10</b>	<b>1.93</b>	<b>54.28</b>	<b>933</b>	<b>20.6</b>	<b>46.7</b>
<b>2</b>	AP	76,210	1.30	51.17	978	19.6	63.3
<b>3</b>	Gujarat	50,671	2.03	58.60	920	21.0	49.4
<b>4</b>	Karnataka	52,851	1.59	57.45	965	20.3	56.4
<b>5</b>	Kerala	31,841	0.90	87.86	1058	22.8	37.5
<b>6</b>	Tamil Nadu	62,406	1.06	64.55	987	21.9	48.4
Source - Col. 2,3,4,5 = 2001 Census						NHFS 3	

**Tabel -2**  
**District wise population**

## CHAPTER 2

### Background and Current Status

#### HEALTH PROFILE OF KARNATAKA

##### Administration:

8. Minister for Health and Family Welfare gives a strong thrust to the Health Policies by formulating Plans. The Minister directs the department to convert the plans into action with a view to benefit the masses especially the poor, downtrodden, women and children.
9. The Principal Secretary Health provides the necessary administrative support to formulate, monitor and implement plans. Provide necessary directions, support and guidance to the Department in implementing plans. The Commissioner Health & Family Welfare co-ordinates and monitors the working of various programs and Project wings of the department. The Department provides Services to the Community by way of implementing various National and State Health Programme in the State. The implementation of the Karnataka Health System Development and Reforms Project is looked after by the Project Administrator who is also the Mission Director of NRHM with integration of NRHM and KHSDRP
10. Director of Health and Family Welfare Services heads the department and is assisted by Additional Directors. There are Joint Directors and Deputy Directors for every programme component. Chief Account officer cum financial Advisor and chief Accounts officer (FW) assist in all matters pertaining finance and accounts. Chief Administrative officer and Chief Vigilance officer assist in matters relating to administration. System Analyst and Senior Programmer assist in matters pertaining to Information Technology.
11. At the District level, there is District Health and Family Welfare Officer assisted by the District Leprosy Officer, District RCH Officer, District Malaria Officer, District TB Officer, DFWO, DAPCO, District surveillance officer. These officers are responsible for implementing and reporting various National and State Health Programmes including Family Welfare Programme and MCH Services. With the merger of NRHM and KHSDRP, District programme management officers assist DHOs in implementing NRHM additionalities. There is DPMU and BPMU at district and block level to add managerial inputs to the programme
12. District Surgeons of the District Hospitals are responsible for providing curative and preventive services including referral services. At the Taluk Level, there are 176 taluk Health Officers and they are responsible for prompt and effective implementation of various National and State Health Programmes in their taluks. At the Primary Health Centre Level the Medical Officers of Health are similarly responsible for the implementation of various National and State Health Programmes.
13. **Health gains:** During the past century and particularly after independence in 1947, several gains have been made in health and health care in Karnataka. Smallpox has been

eradicated. The state has become free of plague and more recently of guinea worm infection. The total fertility rate has come down from 6 in 1951 to 2.10 in 2001.

**Tabel -3**

**A brief picture of the health gains is depicted below.**

HEALTH INDICATOR		1951	1971	1981	1991	2001	2007
Life expectancy at birth (in years)*	Male	37.15	50.9	55.4	58.1	65.6	
	Female	36.15	50.2	55.7	58.6	66.6	
Crude Birth Rate (per 1000 population)*		40.8	31.7	28.3	26.9	22.2	19.9
Crude Death Rate (per 1000 population)*		25.1	12.1	9.1	9	7.6	7.3
IMR (per 1000 live births)*		148	95	69	77	58	47

**\*SRS report**

**Table -4**

**Comparison of Key Indicators for Karnataka Vs Southern States & All India figures.**

Karnataka compares favorably with the National Average in certain key health and demographic indicators.

Southern States & India	MMR	IMR	TFR	Birth rate	Death rate	Institutional deliveries	Full immunisation	Couple protection rate
	SRS 2007		(SRS 06)	SRS 2007		NFHS III		
Karnataka	213	47	2.1	19.9	7.3	66.9	55.0	46.5
Kerala	95	13	1.7	14.7	6.8	99.5	75.3	32.7
Tamil nadu	111	35	1.6	15.8	7.2	90.4	80.8	39.1
Andra Pradesh	154	54	1.9	18.7	7.4	68.6	46.0	52.7
India	254	55	2.7	23.1	7.4	40.7	43.5	28.2

**Source : SRS bulletin & NHP 2008 1.2.11 & NFHS III fact sheet**

### **Health Inequalities:**

**14.** The Dr. Nanjundappa Committee i.e., High Power Committee for Redressal of Regional Imbalances (HPC-FRRI) 2001 report has highlighted the regional disparities in health infrastructure and service facilities especially between South of Karnataka and North of Karnataka. The first Karnataka Human Development Report 1999 has also thrown light

on the regional disparities in the matter of health status. Some of the important findings of the aforementioned reports are given in the following tables.

**Tabel -5**

<b>Issues</b>	<b>South Karnataka</b>	<b>North Karnataka</b>	<b>State</b>
I. No. of hospital beds (2001) per lakh population	85	61	80
II. No. of doctors (Govt + Private) per lakh population	30	25	28
III. % of habitations with 40 or more LPCD(drinking water)	62	44	56

**Source HPC-FRRI 2001.**

**Table -6**

<b>Region / District / State</b>	<b># of Medical institu- tions</b>	<b># of Govt. Drs.</b>	<b># of PHCs</b>	<b>Health Index</b>	<b>Gender- related Health Index (GHI)</b>	<b>Human Develo p-ment Index (HDI)</b>	<b>Gender related Develop- ment Index (GDI)</b>
	<b>per lakh population</b>						
Coastal & Malanad (5 Districts)	7.78	13.6	5.84	0.685	0.689	0.552	0.537
Southern Maidan (8 Districts)	6.07	11.8 6	5.26	0.647	0.599	0.473	0.451
Northern Maidan (7 Districts)	4.37	10.5 7	4.01	0.641	0.537	0.433	0.412
<b>Karnataka</b>	<b>5.24</b>	<b>11.00</b>	<b>4.64</b>	<b>0.654</b>	<b>0.546</b>	<b>0.47</b>	<b>0.451</b>

**\* Source: Karnataka Human Development Report 1999.**

### **Health gaps**

15. However, gaps remain. Large- rural - urban differences remain exemplified by IMR estimates of 52 for rural areas and 33 for urban areas (SRS, 2007). Despite overall improvements in health indicators, inter-district and regional disparities continue. The five districts of Gulbarga Division (Bidar, Koppal, Gulbarga, Raichur, Bellary), with Bijapur and Bagalkote districts of Belgaum division and tribal district Chamarajnagar continue to lag behind. Mal-nutrition in under-five children and anemia in women

continue to remain unacceptably high. Women's health, mental health and disability care are still relatively neglected. Certain preventable health problems remain more prevalent in certain geographical regions or among particular population groups. Structural reforms, as suggested by the Task Force on Health, have to be made and more effective management practices imbued with accountability have to be introduced to ensure swift and effective local responses to health problems. NRHM has brought in flexible financing, community ownership and management in the health care delivery system. There is a rush in pushing the reforms as per NRHM norms, but it takes time for the reforms to percolate down below the line. With the implementation of NRHM programme since the last five years, the State claims proudly to have made some improvement in the health care to the rural mass. However to see the impact of the implementation of the programme of this magnitude it needs longer time.

### **Karnataka State Integrated Policy:**

**16.** The "Karnataka State Integrated Health Policy 2004" articulates the state's long-term vision for the health sector. It states that the mission of the Department of Health and Family Welfare, GOK is to provide quality health care with equity, which is responsive to the needs of the people, and it is guided by the principles of transparency, accountability and community participation.

### **17. Karnataka Health Policy Perspectives and Goals:**

- a) To provide integrated and comprehensive primary health care.
- b) To establish a credible and sustainable referral system.
- c) To establish equity in delivery of quality health care.
- d) To encourage greater public private partnership in provision of quality health care in order to better serve the underserved areas.
- e) To address emerging issues in public health.
- f) To strengthen health infrastructure.
- g) To develop health human resources.
- h) To improve access to safe and quality drugs at affordable prices.
- i) To increase access to a system of alternative medicine.

### **Public Health Approach and Primary Health Strategy:**

**18.** The State recognizes the value of practicing public health and primary health care, for the common good of all citizens. It has committed itself to revitalizing these aspects. Public Health and Primary Health care work in synergy, particularly emphasizing the principles of:

- a) Inter-sectoral coordination at all levels, specifically at the district and below.
- b) Community Participation through Panchayat Raj Institutions and other mechanisms and for involvement in decision-making concerning their own health care.
- c) Equitable distribution of good quality care, and
- d) Use of appropriate technology for health care.

19. The primary health care strategy does not focus only on the primary level but also on the secondary and tertiary levels. Public health recognizes and attempts to address the socio-cultural, socio-economic and demographic factors that affect health status and implementation of health programs. Karnataka State Health Policy would attempt to ensure adequate availability of personnel with specialization in public health to discharge public health responsibility in the state.

**Equity in health and health care:**

20. Equity will be a key policy thrust encompassing four main parameters namely, region, gender, vulnerable groups such as scheduled castes and tribes, and disadvantaged like street children, elderly etc. In the coming years from 2010-11, under NRHM, there are special plans to tackle health problems of the vulnerable population in the high focused districts of Bidar, Bellary, Raichur, Chitradurga, Chamarajanagar, Davanagere and Kolar where the socio-economic and health indicators have been low as per DLHS – III fact sheet.

**Quality of care:**

21. Karnataka Private Medical Establishment Act is passed to ensure acceptable standards of care and assuring quality of care in private medical establishments.

22. Besides the above, the following important components have been envisaged as part of the State Integrated Health Policy with short /long term interventions, keeping in view the set of goals to be achieved.

- a) Multi sectoral and inter-sectoral co-ordination.
- b) Public, private and voluntary sector partnerships.
- c) Health financing.
- d) Health planning.
- e) Health management and administration.
- f) Environmental health.
- g) Nutrition.
- h) Population stabilization.
- i) Education for health personnel.
- j) National Drug Policy.

**23. Policy components on priority health problems and issues:**

- a) Women's health.
- b) Child health.
- c) Communicable/Infectious Diseases (like Japanese Encephalitis, T.B, HIV/AIDS and Vector borne diseases).
- d) Prevention and control of non-communicable diseases.
- e) Emergency health services

24. In conclusion, through the Integrated Health Policy, Karnataka State with additional support from NRHM is placing health high on its agenda. "Health is Wealth" will be

translated into action by allocating adequate human and financial resources, by good governance and institutional capacity building. The state will play a role of facilitator in harnessing resources, energies and ideas from the private and voluntary sector. It will work towards equity, integrity and quality in health and health care.

**Achievements of the department during 2009-10:**

25. Based on Dr. Nanjundappa's Committee Report, new building works for the newly upgraded 51 Community Health Centres have been taken up as per the guidelines and is under progress. Likewise, building works of District Hospitals Gulbarga and Chamarajanagar are taken up and are under progress. An amount of Rs. 21.00 crores is being expended during this year for all building works. Supply of drugs to all Health Institutions in the state has been enhanced. An additional amount of Rs. 26.00 crores has been released in addition to the already existing budget.
26. A Health Insurance Scheme "Suvarna Arogya Suraksha" is being implemented for the farm laborers. Action is being taken to provide more health benefits and an amount of Rs. 35.00 crores is earmarked for this.
27. Action is taken to provide staff and equipments to the upgraded Community Health Centres as per Dr. Nanjundappa Committee Report. It has been intended to upgrade all Taluk Hospitals in the State to a minimum of 100 bedded hospitals. Additional Staff to 41 Taluk Hospitals and existing 117 Community Health Centres as per norms is being filled up.
28. "Control Room" is started in the Directorate of Health and Family Welfare Services, Bangalore, to compile Integrated Information and First Information in the State Health Wing. It is designed to function for 24 hours.
29. Ambulance Vans fitted with essential equipments have been provided to all the 27 District Hospitals for the benefit of accident victims.
30. In all the CHCs, Taluk Hospitals and District Hospitals "Drugs Distribution Centres" have been established in prominent place of the taluk hospital so that it is visible to everyone.
31. Budget for supply of drugs has been enhanced from Rs. 75,000 to Rs. 1,00,000 for each Primary Health Centre and from Rs. 1,00,000 to Rs. 2,00,000 for each Community Health Centre. Budget for supply of Drugs has been enhanced to 2-3 times to Other Hospitals.

Table-7

## Current Infrastructure Status:

Health Institutions in Karnataka (as July 2008)																			
Sl. No.	District	District Hospital		Other Hospitals		Autonomous & teaching		Community Health Centres						Primary Health		Urban PHCs		Sub-Centres	Total Beds
		Nos.	Beds	Nos.	Beds			Taluk		Others		Total		Nos.	Beds	No	Beds		
								Nos.	Beds	Nos.	Beds	Nos.	Beds						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
<b>BANGALORE</b>																			
1	BANGALORE (U)	0		6	1490	11	5072	3	300	3	90	6	390	73	251			185	7203
2	BANGALORE (R)	1	100					3	300	0	0	3	300	46	213			192	613
3	CHIKBALLAPUR	1	100					5	510	2	60	7	570	56	278			184	948
4	CHITRADURGA	1	450					5	500	10	300	15	800	86	312			273	1562
5	DAVANAGERE					1	950	5	500	4	120	9	620	103	446			291	2016
6	KOLAR	1	400	2	274			4	400	2	60	6	460	60	308	1	6	201	1448
7	RAMANAGARA	1	100					3	300	4	120	7	420	54	279			240	799
8	SHIMOGA					1	1000	6	650	5	150	11	800	88	376	1	6	307	2182
9	TUMKUR	1	400					9	900	4	120	13	1020	134	656	1	6	477	2082
<b>BELGAUM</b>																			
10	BAGALKOTE	1	150					5	500	7	210	12	710	47	248			224	1108
11	BELGAUM					1	1000	9	900	15	450	24	1350	146	780	1	6	539	3136
12	BIJAPUR	1	400					4	400	8	240	12	640	64	324			285	1364
13	DHARWAD	1	250			2	1375	3	300	0	0	3	300	31	166	1	6	179	2097
14	GADAG	1	300					4	400	2	60	6	460	35	172			174	932
15	HAVERI	1	100					6	600	5	150	11	750	68	281			290	1131
16	U. KANNADA	1	400					10	1000	3	90	13	1090	78	394	1	6	120	1890
<b>GULBARGA</b>																			
17	BELLARY			1	288	2	1110	6	600	7	210	13	810	70	323	1	6	272	2537
18	BIDAR					1	1000	4	400	6	180	10	580	50	244	1	6	234	1830
19	GULBARGA					1	750	9	900	21	630	30	1530	126	574	1	6	378	2860
20	KOPPAL	1	100					3	300	8	240	11	540	45	220	1	6	183	866
21	RAICHUR					2	1200	4	400	5	150	9	550	52	270	1	6	196	2026
<b>MYSORE</b>																			
22	CH'NAGAR	1	250					3	350	3	90	6	440	57	350			246	1040
23	CHIKMAGALUR	1	400					6	600	4	120	10	720	88	352	1	6	334	1478
24	D. KANNADA					2	965	4	400	6	180	10	580	67	364			431	1909
25	HASSAN					1	1000	7	950	14	420	21	1370	124	566	1	6	420	2942
26	KODAGU	1	400					2	360	6	180	8	540	32	257			188	1197
27	MANDYA					1	1000	6	600	5	150	11	750	106	620	2	12	375	2382
28	MYSORE			1	50	3	1920	6	600	11	330	17	930	135	641	2	12	432	3553
29	UDUPI	1	200					2	200	8	240	10	440	72	374			293	1014
<b>State Total</b>		<b>17</b>	<b>4500</b>	<b>10</b>	<b>2102</b>	<b>29</b>	<b>18342</b>	<b>146</b>	<b>15120</b>	<b>178</b>	<b>5340</b>	<b>324</b>	<b>20460</b>	<b>2193</b>	<b>10639</b>	<b>17</b>	<b>102</b>	<b>8143</b>	<b>56145</b>

## CHAPTER 3

### PLANNING PROCESS

- 32.** NRHM planning committees were formed at State level under the overall supervision of Mission Director. The committees were Core committee and Technical committee. These committees were headed by Project Director (RCH). Core committee consisted of Chief Administrative Officer (NRHM), Joint Director (planning), Demographer, Chief Finance Officer (NRHM), Deputy Director (SICF) and PIP consultant. The Technical committee consisted of all programme heads of all National Disease control programmes, Deputy Directors under RCH, lead and other consultants.
- 33.** A reorientation-training programme was organized at state level for District Health and Family Welfare Officers, RCH officers, DPMOs and DPMs from all the districts for preparation of NRHM PIP for the year 2010-11. The officers were explained in detail on collection of historical data in the annexure, planning process and contents of DHAPs. They were also reoriented on physical and financial planning on infrastructure, manpower, drugs, equipments, and programme related activities for 2010-11. The data was to be collected from VHSC level to District level covering all health facilities in the district.
- 34.** Consultation workshops were also held at the district level under the chairmanship of DCs /CEOs and at taluk level for the departmental officials, NGO partners, and Panchayat members under the chairmanship panchayat presidents at taluks.
- 35.** At state level a PIP review team under the chairmanship the Mission Director and Project director as member secretary, was constituted to review and make recommendations and to consolidate the district action plans. The team consisted of Programme officers of all National programmes and consultants. The districts were asked to make presentations and their plans were reviewed. Modifications were suggested which were later on incorporated by the districts in their plans.
- 36.** State NRHM PIP is a consolidation of the feedback obtained from all the districts on their DHAPs during intensive interactive sessions with District Health & Family Welfare Officers & programme officers in the month of December 2009. Budget allocations to districts are made as per the activities planned by the districts.

## CHAPTER 4

### The Situation Analysis

**Table-8**  
**Current status and goals**

Sl. No.	Goals and its Indicators	Indicator Type	Current status	Projected			
				2008	2009	2010	2011
1.	Reduction in Maternal Mortality(MMR)	HI	213 SRS (2004-06)	190	150	125	100
2.	Reduction in Infant Mortality Rate (IMR)	HI	45 (SRS-2008)	40	30	28	25
3.	Total Fertility Rate (TFR)	HI	2.1 NFHS-3	2.04	2.0	1.9	1.8
4.	Institutional deliveries	HI	67% (NHFS-3) 65.1% (DLHS-3)	75%	85%	90%	99%
5.	<b>Immunization</b>	HI	76.7% (DLHS 3)	80%	90%	95%	100%
a.	BCG		96.90%	100%	100%	100%	100%
b.	DPT		84.80%	90%	100%	100%	100%
c.	Polio		90.30%	95%	100%	100%	100%
d.	Measles		76.70%	80%	90%	95%	100%
e.	Hepatitis B			90%	100%	100%	100%
6.	Malaria	HI	Reduction of mortality by 50% by 2012				
7.	Dengue	HI	Reduction of mortality by 50% by 2012				
8.	Filaria	HI	Total elimination by 2012				
9.	TB cure rate	HI	75%	80%	85%	90%	95%

10.	Fully functional Sub centers	SDI	6399	8143	8143	8143	8143
11.	24x7 PHCs	SDI	389(2007-08)	976	1200	1450	1679
11a	Of which with 2 MBBS doctors			300	500	750	1000
11b	With one additional AYUSH Doctor			477	600	800	1000
12	<b>FRUs</b>	SDI					
a.	Functional		54	192	192	192	200
b.	Bed Occupancy rate		<50%	<50%	50%	60%	>75%
13.	Janani Suraksha Vahini	SDI	74	192	192	192	200
14	Arogya Kavacha (108 services) deployment for maternal health	SDI	Nil	10%	25%	30%	35%
15	<b>IPHS standard</b>	SQI					
a.	CHCs		N.A	N.A	25%	50%	100%
b.	Taluk Hospitals		N.A	N.A	25%	50%	100%
c.	District Hospitals		N.A	N.A	25%	50%	100%
16.	<b>Quality Assurance – NABH Accreditations</b>	SQI					
a.	CHCs		Nil	Nil	25%	35%	50%
b.	Taluk Hospitals		Nil	Nil	25%	35%	50%
c.	District Hospitals		Nil	Nil	25%	50%	100%
17.	<b>Integration of AYUSH with instns.</b>	SDI					
a.	Ayush integration with PHCs		477	477	600	800	1000
b.	Ayush integration with Taluk Hospitals		-	-	29	58	100
c.	Ayush integration with District Hospitals		-	-	12	12	12
18.	Mobile Medical Units	SDI	5	30	60	60	60
19.	No.of fully functional VHSCs	CLI	<b>20000</b>	<b>23026</b>	<b>23026</b>	<b>23026</b>	<b>23026</b>
20.	ASHA	CLI					
a.	Selections(Cumulative)		<b>11200</b>	<b>27190</b>	<b>38190</b>	<b>Nil</b>	<b>Nil</b>
b.	Trained(Cumulative)		<b>Nil</b>	<b>11200</b>	<b>39995</b>	<b>38910</b>	<b>-</b>
c.	Fully functional with drug kits		<b>Nil</b>	<b>7000</b>	<b>11200</b>	<b>39995</b>	<b>38190</b>
21	VHNDs	CLI	Hold 2 VHNDs in every S.C.area every month				
22	Gender Equity	CLI	Effectively implement PC PNDT				

**Table -9****Expected outcomes:**

<b>1. Related to Health parameter:</b>
• IMR reduced to 25/1000 live births by 2012.
• Maternal Mortality reduced to 100 per 1 lakh live births by 2012
• TFR reduced to 1.8 by 2012
• Reduction in Malaria Mortality by 50%
• Upgrading all Taluka hospitals and fully functional CHCs to IPHs standard
• Increased bed occupancy in all FRUs to over 75%
<b>2. at Community level :</b>
• Availability of trained community level worker ASHA at village level, with a drug kit for generic ailments.
• Two Monthly Health and Nutrition Days at every sub centre on fixed days, for provision of immunization, ante/post natal check ups and services related to mother and child health care, including nutrition.
• Community Health days once in 6 months at every PHC in the state on a fixed day to create mass awareness.
• Access to good hospital care through assured availability of doctors, drugs and quality services at PHC/CHC level and assured referral-transport-communication systems to reach these facilities in time.
• Improved access to universal immunization through induction of Auto Disabled Syringes, alternate vaccine delivery and improve mobilization under the programme.
• Improved facilities for institutional deliveries through provision of referral transport, escort and improved hospital care subsidized under the Janani Suraksha Yojana (JSY) for the below poverty line families.
• Improved outreach services to medically under served remote areas through mobile medical units.
• Increase awareness about preventive health including nutrition.
• Availability of safe drinking water.
• Provision of household toilets.

**LEGENDS :**

- HI - HEALTH INDICATOR  
SDI - SERVICE DELIVERY INDICATOR  
SQI - SERVICE QUALITY INDICATOR  
CLI - COMMUNITY LEVEL INDICATOR

## CHAPTER 5

### Priorities, Constraints and Action to overcome constraints:

37. The State of Karnataka took up the implementation with all earnestness from the year 2005-06 itself. Much of the recommendations and guidelines issued by Govt. of India were revolutionary in nature which took longer period for the department to understand, design guidelines and circulars and disseminate the information through workshops and trainings etc. The manpower provision was and is the greatest challenge in the entire gamut of implementation.

**Table -10**

Sl. No	Priorities	Constraints	Action taken to overcome constraints
1	Functionalise facilities – Establishing fully functional Sub Centers / 24 x 7 PHCs, Making 192 CHCs into functional FRUs.	Poor physical infrastructure  Non-availability of doctors/ paramedics	<ul style="list-style-type: none"> <li>• Strengthen Infrastructure</li> <li>• Contractual appointment and support for capacity development</li> <li>• Pooling of staff/optimal utilization</li> </ul> Training of MOs in LSAS and EmOC and posting them to FRUs to make them functional
2	Increasing and improving human resources in rural areas	<ul style="list-style-type: none"> <li>• Shortage of doctors</li> <li>• Shortage of ANMs/MPWs.</li> <li>• Lack of any plan for career advancement or for systematic skill up gradation.</li> </ul>	<ul style="list-style-type: none"> <li>• Local preference while selecting staff on contract.</li> <li>• Multi-skills of doctors / paramedics and continuous skill up gradation through NRHM &amp; KHSDRP.</li> <li>• Convergence with AYUSH</li> <li>• Partnership with non-governmental stakeholders.</li> </ul>
3	Accountable health delivery	Poor referral system Panchayati Raj Institutions / user groups had little say in health system	<ul style="list-style-type: none"> <li>• Referral chain from village to hospital</li> <li>Formation of VHSCs</li> <li>• Control and management of Health facilities by PRIs</li> <li>• Untied funds</li> </ul>
4	Empowerment for effective decentralization and Flexibility for local action	• Lack of indicators and local health status assessments that can contribute to local planning.	<ul style="list-style-type: none"> <li>• Internal evaluation of functioning 24 x 7 PHCs under taken</li> <li>Planning for 2010 -11 by integrating village level plans upto district level and aggregated all DHAPs to make state PIP</li> </ul>
5	Reducing maternal and child deaths and	<ul style="list-style-type: none"> <li>• Lack of effective linkages for referrals</li> <li>• Lack of equity/sensitivity in</li> </ul>	<ul style="list-style-type: none"> <li>• Planned to make functional public health system including 192 CHCs as FRUs, (143</li> </ul>

	population stabilization	<p>family welfare services/ counseling.</p> <ul style="list-style-type: none"> <li>• Non-availability of Specialists for anesthesia, obstetric care, pediatric care, etc.</li> <li>• No system of new born care with adequate referral support.</li> <li>• Need for universalization of ICDS services and universal access to good quality antenatal care.</li> <li>• Need for linkage with parallel improvement efforts in social and gender equity dimensions.</li> <li>• Lack of linkages with other dimensions of women's health and family friendliness of public health facilities.</li> </ul>	<p>conducting LSCS) and 1200 PHCs planned to be made 24X7.</p> <p>Functioning 108 Aorgya Kavacha ambulance services</p> <ul style="list-style-type: none"> <li>• SBA training for MOs, SNs &amp; ANMs in phased manner</li> <li>• Encouraging Institutional delivery through various schemes like Madilu, JSY.</li> <li>• Quality services at facilities in phased manner by converting PHCs into model PHCs.</li> <li>• Expanding facilities capable of providing contraception including quality sterilization services on a regular basis so as to meet existing demand and unmet needs.</li> <li>• Selection &amp; training of ASHA &amp; functional ASHAs in districts</li> <li>• New born care facility at FRUs for reducing neo natal mortality;</li> <li>• Active Village Health and Sanitation Committee;</li> <li>• Expanding the ANM work force especially in remote areas and in larger village and semi-urban areas.</li> <li>• Planned synergy of ANM, AWW, ASHA work force and where available with local SHGs and women's committees.</li> <li>• Linkage of all above to the Panchayat committee on health.</li> </ul>
6	Action for preventive and promotive health	<ul style="list-style-type: none"> <li>• Lack of emphasis on locally and culturally appropriate health communication efforts.</li> <li>• Insufficient action on promoting healthy lifestyles</li> </ul>	<ul style="list-style-type: none"> <li>• Convergence with other departments/institutions</li> <li>• IEC Training and capability building</li> <li>• Working together with</li> </ul>

		<p>whether it be fighting alcoholism or promoting tobacco control or promoting positive actions like sports/yoga etc.</p> <ul style="list-style-type: none"> <li>• Need for improved school health programmes (ARSH)</li> </ul>	<p>ICDS/TSC/ CRSP/SSA/MDM</p> <ul style="list-style-type: none"> <li>• Improved School Health Programmes &amp; initiation of Suvarna Arogya Chaitanya programme</li> <li>• Common approach to IEC for health</li> <li>• Involvement of PRIs in health through VHSCs.</li> </ul>
7	Disease Surveillance	<ul style="list-style-type: none"> <li>• Vertical programmes for communicable diseases</li> <li>• No integrated / coordinated action for disease surveillance at various levels in place yet.</li> <li>• No periodic data collection and analysis and no district and block specific epidemiological data available</li> </ul>	<ul style="list-style-type: none"> <li>• Horizontal integration of programmes through VH&amp;SC, SHC, PHC, CHC.</li> <li>• Initiation and Integration of IDSP at all levels. Epidemiological capabilities.</li> </ul>
8	Forging hamlet to hospital linkage for curative services	<ul style="list-style-type: none"> <li>• Entitlements of households not defined</li> <li>• No community worker in all districts</li> <li>• No well defined functional Referral/transport/communication system at community level.</li> <li>• Institutionalized feedback mechanism yet to be formulated on performance of ASHA.</li> </ul>	<ul style="list-style-type: none"> <li>• Village level &amp; facility level surveys/collection of data using HMIS formats already done in all the districts. This will facilitate for local level planning.</li> <li>Linkages with VHSCs/SHCs / PHCs/ CHCs for referral services.</li> <li>Around 900 ASHAs trained in the first batch started working in the field only from October 2008. Around 21000 ASHAs are functioning in the field as on November 2009.</li> <li>Selection &amp; training of AHSAs in all the districts is planned during 2009-10.</li> </ul>
9	Health Information System.	<ul style="list-style-type: none"> <li>• Absence of a Health Information System facilitating smooth flow of data from grass root level to the State.</li> </ul>	<ul style="list-style-type: none"> <li>• A fully functional HMIS in place. Data flow from SC level is ensured and consolidation of data at all levels is being done.</li> <li>• Publication of State and District Public Reports on Health.</li> </ul>

11	Work towards women's empowerment and securing entitlements of SCs /STs /OBCs /Minorities	Standard package of interventions under current schemes. Coverage and quality of services to women, SCs/STs/OBCs/ Minorities not tracked health institution wise. No analysis of access to services and its quality.	Schemes like Madilu, Prasuthi Araiike, JSY and Thaiy Bhagya is being implemented and also extended during 2009-10. Outreach services by Mobile Clinics are also being implemented.
12	Convergence of programme for combating/preventing HIV/AIDS, malnutrition, providing safe drinking water etc. with community support.		<ul style="list-style-type: none"> <li>• Integration of HIV with RCH programmes</li> </ul> Convergence with allied departments planned.

**Part –A**  
**REPRODUCTIVE AND CHILD HEALTH PROGRAMME –II**

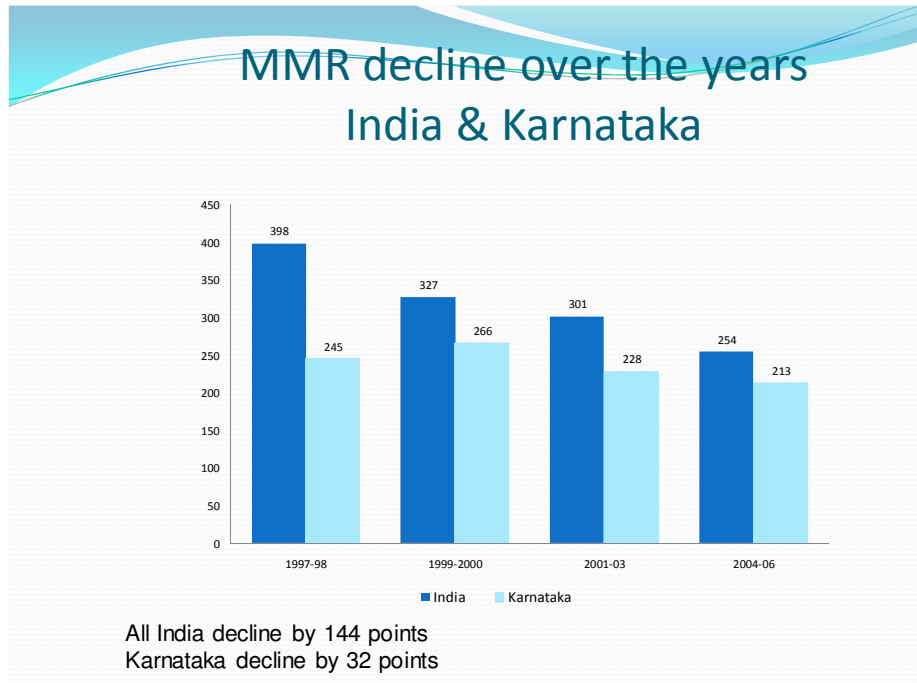
**CHAPTER 6**

**MATERNAL HEALTH**

**Background**

38. One of the most important programmatic goals for the State of Karnataka is a reduction of maternal mortality rate to 100 by the year 2012. As per the SRS 2004-06, the maternal mortality rate for Karnataka is 213 per lakh live births while that for India is 254 per lakh live births. Maternal mortality is considered one of the significant indicators of women's health, as it not only indicates the maternal deaths but also the quality and accessibility of health care services. Even after more than four and half years of the program implementation, the MMR has remained uncomfortably high.

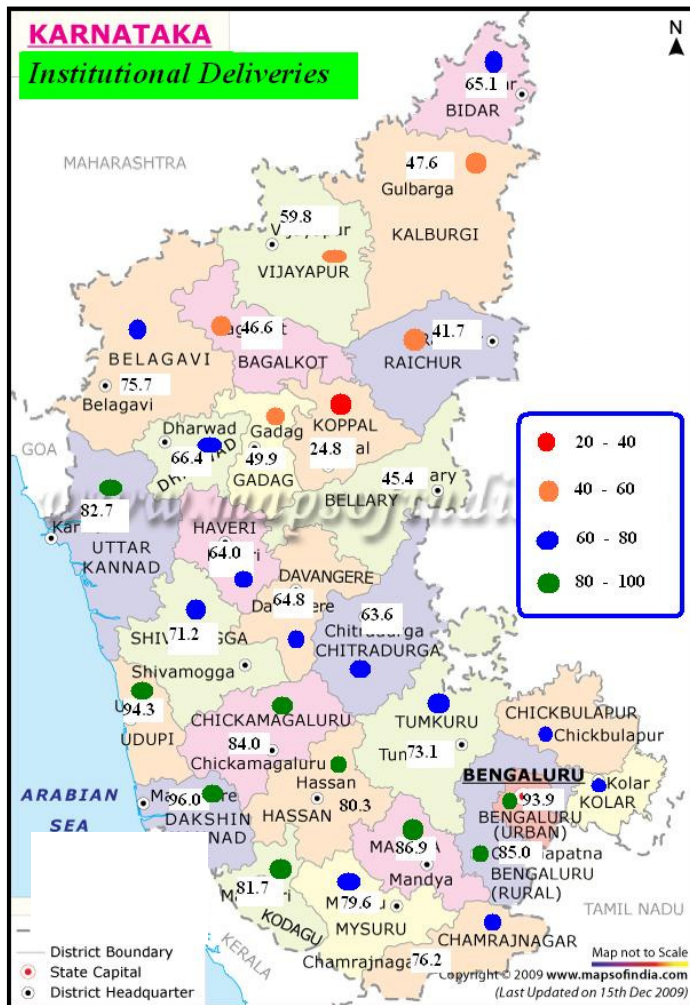
Diagram-2



Situational analysis:

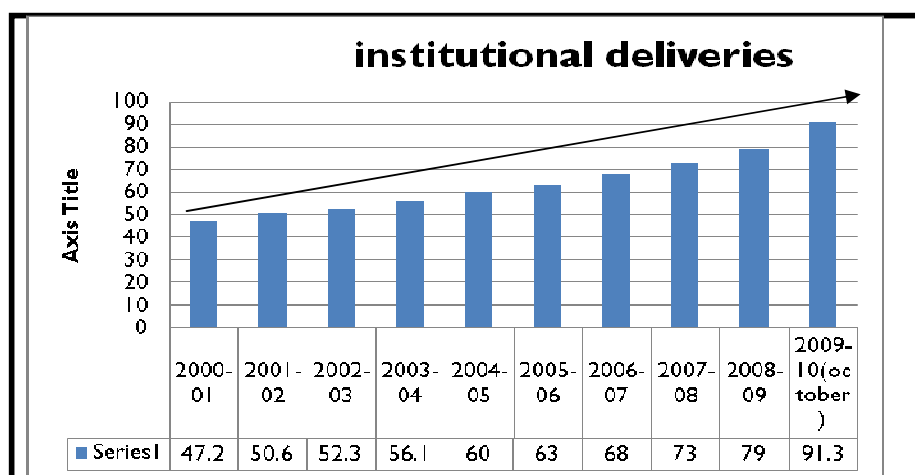
Diagram-3

a) Institutional deliveries :



39. One of the strategies to prevent the maternal death is the institutional deliveries. The Maternal health indicators are low in the Northern districts of Karnataka (Gulbarga and Belgaum division) where the institutional deliveries are low compared to institutional delivery rates in southern Karnataka which are more than 90%. The percentage of institutional deliveries is depicted in the map below as per DLHS-3: **Improvement** in the institutional deliveries has been very encouraging. (As per the department data)

**Diagram-4**



**Goals for maternal health for Karnataka:**

40. The following goals are envisaged for maternal health for Karnataka so that women will be able to go through pregnancy and childbirth safely and the outcome of pregnancy is successful in terms of maternal and infant survival and well being:

**Table-11**

**Goals for maternal health:**

Indicators	Current status	2009-2010	2010-2011	2011-12
Reduction in MMR	213 SRS (2004-06)	150	125	100
Institutional deliveries	65.1%(DLHS-3)	85%	90%	99%
Reduction in IMR	45 SRS (2008)	30	28	25
Total fertility rate	2.07(NHFS-3)	2.0	1.9	1.8

**41. Objectives:**

- a) Improving coverage and quality of universal antenatal care, identification of high risk pregnancies and early referrals.
- b) Tracking of missed out antenatal cases
- c) Improving nutrition and treatment of anemia.
- d) Quality intra natal care by trained staff through improved service
- e) Identifying vulnerable groups and providing adequate services.
- f) Involvement of the private sector
- g) Resident doctors & staff

## **Strategies:**

### **42. Service provision**

- a) 1200 out of 1679 PHCs to be made functional 24x7
- b) 192 FRUs to be fully operationalized.
- c) All 192 FRUs to have Janani Suraksha Vahini
- d) Arogya Kavacha despatches for Maternal Emergencies
- e) Tayi Bhagya scheme under PPP.
- f) Mobility Support to ANMs , LHV's, Male Health worker, Senior health inspector and MOs for monitoring
- g) Remote Area allowance for doctors , staff nurses and paramedical staff
- h) Filling up vacant ANM Posts and providing second ANM.
- i) Trainings on Maternal Health (SBA, EMOC, LSAS, RTI/ STI, MTP)

### **Steps to improve Full ANC, Consumption of IFA**

- a. Early registration of ANC (< 12 weeks)
- b. Strengthening VHNDs
- c. Orientation of VHSCs members
- d. ANC tracking by ASHA / ANM

### **Steps to improve 48 hrs stay**

- a. Providing meals for in-patients and one accompanying attender.
- b. Women and children friendly services like Hot water supply, 24 hours drinking water supply, 24 hours electricity, clean toilets etc.
- c. Action initiated for 48 hours stay in the form of a circular to the Districts.
- d. Distribution of benefits like JSY, Prasuti Arike, Madilu within 48 hours.

### **Steps to improve PNC**

- a) Post-natal visits will be ensured by ASHA / ANM on 1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup>, 7<sup>th</sup>, 14<sup>th</sup> and 21<sup>st</sup> day.

### **43. Demand generation**

- a) Janani Suraksha Yojana (1<sup>st</sup> & 2<sup>nd</sup> BPL & SC/ST women after delivery)
- b) Madilu (post natal care kit for BPL women for 1<sup>st</sup> & 2<sup>nd</sup> delivery)
- c) Prasuthi Arike: monetary benefit for Ante-natal & post-natal care for BPL women. (1<sup>st</sup> & 2<sup>nd</sup> delivery)
- d) Thayi Bhagya (based on the Chiranjivi scheme of Gujarat)
- e) Capacity Building of VHSCs& functional VHNDs

**Table-12**

**Maternal Health Indicators: Karnataka (source DLHS)**

Sl. No.	Indicator	DLHS-2 2002-04	DLHS-3 2007-08
1	3 Antenatal check ups	78.6%	81.6%
2	Consumption of IFA for 90 days	33.0%	40.7%
3	Safe deliveries	66.5%	71.5%
4	Institutional delivery	57.95	65.1%
5	Home delivery	41.9%	34.1%
6	Post natal care within 2weeks of delivery	NA	69.2
7	Prevalence of anemia	48.6	59.5

**Activities:**

**Community and Sub center level :**

**44. Village Health and Sanitation Committees (VHSC):** The VHSCs will track the antenatal mothers and EDD will be communicated to Arogya Kavacha (108) thereby promoting institutional deliveries and reducing MMR and IMR. Awareness programs for pregnant women to promote adequate nutrition, food intake and rest during pregnancy. Adequate stress on addressing maternal nutrition, prophylaxis and treatment of anemia and nutrition counseling. ASHAs and AWW are trained to organize focus group discussions on maternal deaths

**45. Accredited Social Health Activists (ASHAs) :** ASHAs have been trained and positioned, to create awareness and provide information as well as counsel on the advantages of antenatal checkups and institutional deliveries. Each ASHA is provided an incentive for bringing the pregnant woman for early antenatal registration as well as regular antenatal checkups. She is also provided an incentive to accompany the pregnant woman to the institution for delivery. This will assist in improving coverage and quality of antenatal care, which is 81.6 % as per DLHS-3. ASHAs will assist the ANM in post natal visits on day 1, 3, 5,7,14 and 21 and encourage early breast feeding.



**46. Seemantha program:** ‘Samootha Seemantha’ or Community Bangle ceremony and Celebration which has proved to be a good strategy for getting the community actively involved in spreading awareness about safe delivery, post-natal care etc. . On this occasion, pregnant women are honored with a Kum-Kum (Vermillion on their forehead) and are given some gifts like blouse pieces and bangles. This is being conducted at the PHC level and has shown tremendous response in all the districts. **This program also ensures that all the pregnancies are registered with the ANM of the area with the help of the ASHA and the anganwadi worker .**



#### **ANM for vacant sub centers:**

**47.** There are 8143 sub centers in Karnataka out of which 933 sub centers do not have the services of ANM. This has contributed to the lack of service provision at the sub centers. To improve the maternal health services, it was proposed to provide service of one Junior Health Asst. Female (ANM) or Staff Nurse to such vacant sub centers. They will provide antenatal care and detect the high risk cases as also intra natal and post natal care. All these issues will be addressed if ANMs are posted to these vacant Sub centers. Till date 447 ANMs have been appointed on contract and are in position.

( budget provision has been made for 690 ANMs)

#### **ANC Registration Booklet (Thayi Card) :**

**48.**Thayi card is a comprehensive Antenatal registration booklet .It encompasses all the mother and child health parameters from early ANC registration to post natal follow up, Immunization of child, weight gain record etc. These cards help in pregnancy tracking and the immunization and growth of the child with provision for recording the disbursement of the money for JSY/Prasuthi Arai ke as well as the disbursement of Madilu kits. It is proposed to provide ANC registration booklet for all the antenatal cases.

## **Monitoring and evaluation**

### **ANM/ Male Health Worker :- Mobility Support**

**49.** ANM/ Male Health Workers apart from conducting the activities in the sub center also have to conduct field visits. Hence support for mobility to the ANM/ Male Health Worker will go a long way in improving antenatal care as well as to detect drop outs and high risk cases. **To assist the ANM to monitor the work of the ASHAs at the village level mobility support has proved to be a useful incentive.**

### **Rent for sub centers:**

**50.** In Karnataka 3357 sub centers do not have building of their own. The sub centers function out of rented buildings. It is proposed to provide rent facilities to all these sub centers. Sub centers are crucial to the provision of health care services. The rent facility will facilitate the stay of Junior Health Asst. (female) at her place of posting and assist her to provide maternal and child services. ( Budget provision has been made for 2282 sub centers )

### **Additional ANM: Strengthening of services in 6 ‘C’ category districts:**

**51.** 6 ‘C’ category districts namely Bidar, Gulbarga, Raichur, Koppal, Bijapur and Bagalkote, the health parameters are poor. One sub center in the Northern Districts caters to a population of 6521 – 8266 while as in Southern Districts one sub center caters to a population of 4098 approximately. The area covered by the ANM is large and field work suffers as a consequence. To strengthen and improve services in these districts, services of **2<sup>nd</sup> Junior Health Asst. (Female)/ Staff Nurse** is proposed in nearly 1291 sub centers. The program is implemented from 2007-08 and 449 of these 2<sup>nd</sup> ANM /staff nurses are in position.

( Budget provision has been made for 794 ANMs)

### **Integration of PPTCT program of KSAPS with NRHM and Yeshaswini scheme:**

**52.** Integration of Prevention of Parent to Child Transmission (PPTCT) Programme of KSAPS with NRHM was undertaken for the first time in the Country since April 2008 in Karnataka. Under this scheme, all pregnant women are registered, counseled and tested for HIV from the second trimester onwards. Those ANCs detected positive are counseled by ANM /ASHAs, counselors of ICTCs to access a complete package of PPTCT services under NACO including ART services which not only enhances her lifespan but also prevents HIV transmission to her baby.

**53.** Birth planning is done in close consultation with the ANC and linked to the Yeshaswini scheme (National Health Insurance Scheme in Karnataka) where she can have a cashless delivery in any of the Yeshaswini Network Hospitals. So far, 2933 cases have been registered by the Yeshaswini scheme and 479 have already delivered – 279 normal deliveries and 200 Caesarian sections. An equal no.of cases have also delivered in Public Sector Hospitals.

54. The ANMs/ASHAs and MO PHCs play of pivotal role in the follow-up of these cases after detection of HIV positive ANC's & accompany them to the Hospital at the onset of labour pains, ensure administration of T. NVP and Sy. NVP to mother & baby follow her up postnatally up to 18 months to know the HIV status of the baby. (Annexure & flowcharts have been prepared for effective implementation of this integration model)

55. The Budget requirement under this component during FY: 2010-'11 will be approximately Rs. 150.00 lakhs for 2500 beneficiaries. This home-grown model of PPTCT-NRHM integration has been is being replicated by all other states in India.

56. During 2009-'10, 600 24 x 7 PHCs were identified to establish ICTC functions in them and during 2010-'11 the remaining 24 x 7 PHCs will also initiate ICTC functions in them. 31 Mobile Health Clinics under NRHM- KHSDRP will commence ICTC functions from Jan – 2010 onwards. 83 ICTCs located in PHCs have been integrated with NRHM and total budget of 249.28 lakhs is required to meet the costs towards salaries, TA/DA, contingencies, HIV test kits and consumables.

**57. Out come of the Scheme:**

Till date 2933 HIV +ve ANC's has been registered with the Yeshasvini Scheme. The Total No. of deliveries un-till 31.12.09 has been 479 out of which 278 are normal deliveries and 201 are Caesarian sections.

Infact, more than 250-300 HIV+ve pregnant women have actually delivered in public sector hospitals whose claims have not reached the Yeshasvini scheme authorities for reimbursements due to lack of co-ordination between the hospital staff and Yeshasvini scheme.

The District AIDS prevention and control unit officers have been instructed by PD, KSAPS to immediately send their claims within 10 days.

An amount of Rs. 1874131/- (Eighteen lakh Seventy Four Thousand One Hundred and Thirty One Only) has been reimbursed to hospitals who have conducted HIV +ve ANC's deliveries until 31.12.09.

**Sub centers logistics:**

58. Karnataka has 8143 sub centers offering a range of services with special emphasis on maternal and child Health Services. It is required to supply basic investigation consumables and drugs as per the specifications prescribed by the MoHFW, Govt of India.

Sub centers (8143)
Haemoglobin estimation books (@ 100 B/SC) = 8143
Urine testing strips 1000 / sub centers
*SSD kits – 1.5 Lakhs kits
Drugs
Kit A & Kit B

\* **SSD Kits Components:** Sterile Gauze, Sterile cotton thread, Chloro hexadin lotion, Absorbent cotton, Sterile SS Razor Blade, Soap, Sterile Gloves, Sterile pad, Sterile umbilical card clamp, Sterile towel, Sturdy plastic sheet. All the above product have been sterilized by Gamma Radiation. Approximate cost of each kit is Rs. 50/-.

- For reduction in prevalence of anemia among the pregnant women it is essential that all the sub centers are provided with hemoglobin estimation books
- Pre eclampsia and Pregnancy induced hypertension are to be detected at the earliest by the urine testing for which urine strips are provided at each sub center
- BP instrument and weighing machines are mandatory for each sub center
- Safe Sterile Delivery Kits to be provided for home deliveries as well as sub center deliveries to ensure aseptic labore.

**Use of Tab. Misoprostol for prevention of PPH at sub centers and home deliveries:**

59.Tab Misoprostol is used for the management of PPH. This drug is provided for the deliveries conducted at the sub center level as well as the deliveries conducted at home by skilled Birth Attendants. The target deliveries are approximately 1.5 lakh. 3 tablets of misoprostol are required per case. Hence a total of 4.5 lakh tablets would be procured.

**Activities at PHC Level:**

Indicator	Type	Current status	Goals	
			2010-11	2011-12
24x7 PHCs	SDI	974	1200	1679

60. Primary Health Centers are the cornerstone of rural health services. It is the first port of call in rural areas for the sick and those who directly report or are referred form Sub-centers for curative, preventive and promotive health care. There are 2193 PHCs (including 516 upgraded PHC’s) in Karnataka. Of the original 1679 PHC’s, during the year 2009-10, 1000 PHCs were proposed for 24x7 out of which 974 were identified. During 2010-11 additional 200 PHCs have been proposed for providing 24x7 services. Hence a total of 1200 PHC’s as 24x7 PHCs have been proposed as 24x7 PHCs. The Service package that will be provided at these PHCs is as follows:

**Contractual Medical Officers for high performing PHCs/CHCs and FRUs:**

61. For round the clock services at the PHCs it is essential to have one MBBS doctor at each PHC. Services of 100 contractual MBBS Doctors was provided in 6 ‘C’ category districts as an additional MBBS Doctor to improve the maternal and child

health service delivery at PHCs from RCH-I. It is proposed to continue their services during FY: 2010-11 through filling up of existing vacancies from District Health Society.

**As the workload in good performing 24 x7 PHCs is high,** it is proposed to appoint **one more contractual MBBS Doctor** to provide 24 x 7 services at the single doctor PHC's which are conducting more than **15 deliveries per month**. There are totally 425 24 x 7 PHCs / CHCs with more than 15 and 30 deliveries per month respectively. As it is very difficult to get 425 MBBS doctors, the budget is proposed only for 177 MBBS doctors on contract basis.

#### **Contractual Staff Nurses at 24 x 7 PHC's:**

**62.** 2883 Staff Nurses (including regular staff nurses) are working at the identified 24x7 PHCs, this has substantially improved the delivery performance as well as the early identification of complications. The institutional delivery has shown an upward trend. It is planned to identify additional 200 PHC's in 6 'C' category districts and in those districts where MMR & IMR is high as compared to the State average. These 200 PHCs will function as 24x7 PHCs.

#### **Night assistant in 24 x 7 PHC's:**

**63.** An assistant to staff nurse is identified by **ARS** of that 24 x7 PHC. She has to stay at the PHCs during the night time and assist staff nurse in the delivery. She is a community resource who will help / assist the staff nurse as there is acute shortage of staff at night. This initiative has worked well in the last year as most of the PHCs have hired Night assistants.(budget through ARS funds).

#### **Difficult /Remote Area Allowance:**

#### **Most remote PHC (Hard areas) and more remote PHCs:**

**64.** Generally doctors and staff nurses are not keen in serving in the remote rural areas. They have to be motivated for taking up jobs in remote PHCs. These areas have been identified keeping in mind the geographical areas, the bus routes, availability of regular staff etc. The PHC's so identified, are limited to a maximum of 20% of PHC's in the districts. Total number of PHCs selected is 109 for most remote and 218 for more remote PHCs. It is proposed to continue assistance as in the previous year to encourage Medical Officers and Staff Nurses per PHC to work in these hard to reach areas. Their performance is reviewed on a regular basis in the monthly meetings. Clear guidelines as to the criteria of selection of these areas have been circulated. The incentives are performance based and issued on the basis of their staying at the head quarters. Such PHCs are identified by the District Health Society on the criteria mentioned in guidelines. MOs of More and Most backward PHCs will get Rs. 2000 flat as backward area allowance to encourage the doctors to work in backward PHCs. MOs of most remote area PHCs will get Rs. 10,000/- if they stay in the head quarters.

**65.** During the FY 2010-11 incentives proposed are not only for the doctors and staff nurses but the other paramedical staff as follows: The incentives have been built not

on the hierarchy but on the MCH workload and their value contributions to achieve MDG goals.

## Criteria

### A More Remot areas:

- No roads and Transport facility, Forest and Tribal Area
- Naxalite areas (Socio economically backward area)
- >150 MMR
- > 50 IMR
- Vacant since 1 year (Medical and Para-medical staff)
- No Schools and No basic facilities areas

### B. Most Remot Areas:

- Less transport facility
- Heavy rain areas
- 100-150 MMR
- 40-50 IMR
- Vacant since 6 months to 1 year (Medical and Para-medical staff)
- No Schools and No basic facilities areas

**Table:13**

Personnel	Most difficult	More difficult
Doctor (stay in the HQ)	Rs 10000 pm	Rs. 2000 pm
Doctor (backward area allowance)	Rs. 2000 pm	Rs. 2000 pm
Staff nurse (stay in the HQ)	Rs 3000 pm	Rs 1500 pm
BHEO (stay in the HQ)	Rs 800pm	Rs 400pm
Paramedical Ophthalmic Assistant (stay in the HQ)	Rs 750pm	Rs 375pm
LHV (stay in the HQ)	Rs 750pm	Rs 375pm
Sr. Health Inspector (stay in the HQ)	Rs 750pm	Rs375pm
ANM (stay in the HQ)	Rs 600pm	Rs 300pm
Lab Technicians (stay in the HQ)	Rs 500pm	Rs 250pm
Male Health workers (stay in the HQ)	Rs 500pm	Rs 250pm
Pharmacist (stay in the HQ)	Rs 500pm	Rs 250pm
Group 'D' (stay in the HQ)	Rs 400pm	Rs200pm

## **Monitoring and Evaluation of programs:**

### **Mobility Support:**

#### **PHC Medical Officers:**

66. One Primary Health Center caters approximately to a population of 25,000. The Medical Officer apart from managing the clinic at the PHC has to manage and supervise and monitor all the National Health Programs and also has to monitor the work turned out by the ANMs, Male health workers, ASHAs and also has to conduct outreach services in the inaccessible areas. For these activities at present there is no vehicle facility for most of the PHC doctors, which hampers the program. In order to improve the maternal and child health parameters it is essential to provide the doctors with mobility support. It is proposed to provide a sum of Rs 500/pm as mobility support to the administrative medical officer of the PHC.

#### **Mobility support for Senior Health Asst. (Female) / Lady Health Visitor (LHV)**

67. The Senior Health Asst. (female) /LHV have to supervise the work of ANMs in the entire PHC. She has around 3-4 sub centers and has to visit 25-30 villages, monitor the work of the ANMs. Without the mobility support the LHVs find it difficult to monitor the program It is proposed to extend mobility to one Senior Health Asst. (female)(LHV)/PHC @ Rs.300/ pm

#### **Mobility support for Senior Health inspector and BHEO.**

68. The Senior Health inspector and BHEO has to supervise the National Health Programs. He has to move around the PHC area has to visit 25-30 villages to implement malaria control activities, motivate for NSVs. Without the mobility support the Senior Male Health Assistant finds it difficult to monitor the program It is proposed to extend mobility support at the rate of Rs.300/- p.m. to him.

## **Drugs and Consumables**

69. The basic drugs and consumable required at the 24x7 PHCs will be provided. The brief details are as follows.

Urine testing strips (@ 1000 strips x 24 x 7 1200) through ARS
1 Drug kit for PHC as per the GOI guidelines per 24 x 7 PHC x 1200 PHC's supplied by GoI.
RTI/STI drug kit per 24 x 7 PHC x 1200 PHC's) supplied by GoI.

### **Stationery Printing: Registers and formats:**

70. It is necessary to provide Medical case Sheets, Referral slips, parturition register for proper registering of deliveries etc. Hence provision has been made to print these formats and registers and distribute to the field functionaries very much in advance.

### **Monitoring and evaluation of the 24X7 PHCs:**

#### **Monitoring visits by the Taluka Officer:**

71. Every officer to visit at least 4 PHCs in a month and guide MOs in detail to provide remedial actions for each PHC not conducting more than 10 deliveries in a month. The officers also give cursory visits to minimum 10 PHCs pm and all FRUs. (Incentive of Rs. 750/- pm for all THOs)

#### **72. Training:**

- Training of MOs in Basic Obstetric care
- Training of Staff nurses/LHV/ANM in SBA

#### **SBA Training:**

- Objective: enabling the MO, Staff Nurses and ANM working at 24x7 PHC, CHC, FRU to perform Basic Obstetric care at these institutions and thereby reducing the morbidity and mortality among mother and neonate.
- Medical Officer of the 24x7 PHC/CHC, Staff nurses from 24x7 PHC/CHC/FRU and ANM from 24x7 PHC's are trained under Skill birth attendance training and are placed back in the same institutions so that these institutions are fully operationalized.
- Since 2006, 3504 staff nurses, 790 ANM's have undergone training in SBA and are placed back in the same institutions.

#### **Labor room:**

73. All the labor rooms to follow aseptic precautions and all guidelines and protocols as per the SBA Training program

### **Establishment of FRUs to provide 24 hrs emergency Obstetric and New born Care services:**

74. Further reduction in the MMR of the State depends on the provision of the emergency obstetric care services as close to the community as possible. The State has entered a phase where quality intra natal and post natal care is essential for the mother's survival.

Indicator	Type	Current status	Goals	
			2010-11	2011-12
FRUs	SDI	142	192	200

**Phasing:** It is proposed to functionalize the FRUs in a phased manner. A total of 192 FRUs are identified and as of date 142 are functional as of November 2009. **In order to ensure the services the following activities are proposed:**

**Sourcing in Specialists for FRU's/Taluk Hospitals:**

**75.** The key constraint to operationalize these FRUs till now is shortage of specialist i.e. gynecologist, Anesthetist and pediatricians. Specialists are not available in many FRUs. Hence to overcome the shortage of specialists at FRU it is proposed to insource specialists.

**76. Insourcing of specialists.** It is decided to give a lump sum amount of Rs 50,000 per FRU to be used by that FRU to provide obstetric care services either by hiring/ contractual appointment / case to case basis (i.e. Rs.1500/- for Obstetrician and Anaesthetist and Rs.500/- for paediatrician) through the District Health Society. This strategy was introduced in the year 2009-10. It is proposed to continue sourcing in services of Obstetrician, Anesthetist and Pediatrician to FRUs. It is proposed to make such services available at all 192 FRU's .

**Training of MBBS doctors in the life saving Anesthesia and obstetrics skill:**

**77.** To overcome the shortage of specialists, a scheme for training MBBS doctors as anesthetist and gynecologist has also been in operation.

- Training of MBBS doctor in life saving anesthetic skills LSAS (18 weeks) and obstetrics (16 weeks) for emergency obstetric care has already taken up in Karnataka. Following the training these doctors are posted to identified FRUs to provide EmOC services.

**a. LSAS**

- i. Objective: enabling the MBBS doctors working in the districts to administer the anaesthesia for the emergency obstetrics case in the absence of the qualified Anaesthetist at FRUs.
- ii. MBBS doctors working in the districts are trained in LSAS for 18 weeks as per the guidelines provided by GOI and the training is done through Department of Anaesthesia at 4 Medical colleges namely: Bangalore Medical and Research Institute, Bangalore, Mysore Medical college, Karnataka Institute of Medical Sciences Hubli, Vijayanagara Institute of Medical Sciences Bellary. Extended practice training is done at Districts Hospitals which are having Anaesthetist who is under gone TOT.

**b. EmOC:**

- i. Objectives: enabling the MBBS doctors working in the districts to perform LSCS and other emergency procedure for emergency obstetrics cases at FRU in the absence of the qualified Obstetricians.

- ii. MBBS doctors working in the districts are chosen as per the GOI guidelines and are trained for 16 weeks in EmOC as per the FOGSI guidelines. The training is done through department of OBG at Bangalore Medical and Research Institute, Bangalore, Mysore Medical College, KIMS, Hubli and 10 districts hospitals which are identified and are with Obstetricians who are trained by FOGSI.
  - iii. Since 2008, 40 MBBS doctors from various districts are trained and placed at 40 FRUs
- To encourage these doctors an incentive of Rs. 1000/- per case for conducting caesarian section is proposed subject to a maximum of Rs. 10,000/- per month.

**Outcome:**

- 71 MBBS doctors (Nov-09) are trained in LSAS, out of which 50 are giving anaesthesia (70%). 2589 (Dec-09) cases have been handled by LSAS trained doctors.
- 40 MBBS doctors (Nov-09) are trained in EmOC, out of which 32 have been posted to identified FRUs. Out of which 18 have conducted Caesarean section (56%). 354 Caesarean sections (Dec-09) have been conducted.

**Detailed budget is provided.**

Incentive for LSAS & EmOC during 2010-11	<b>96.00 lakhs</b>
Recurring cost for manpower (OBG and ANae specialists) required for BMC under EmOC programme	<b>20.00 Lakhs</b>
<b>Total budget required</b>	<b>116.00 lakhs</b>

**Contractual staff nurses at First Referral Units:**

78. Out of the identified 192 FRU's in Karnataka, 142 FRUs are conducting LSCS. To strengthen maternal health services at these 192 FRU's, it is proposed to continue services of two Staff Nurses at FRU.

**Contractual staff nurses for Community Health Center (CHC):**

79. Under NRHM, the services at PHC's and FRU's, have been strengthened in terms of manpower, equipments, logistics, transport facilities etc. There are about 140 CHC's (Non FRUs), at sub Taluka level which are 30-bedded hospitals, already providing Maternal and Child Health services. Some of these CHC's do not have sufficient staff nurses, and workload is very high. Hence it is proposed to provide services of two contractual staff nurses for 140 CHC's to strengthen NRHM activities with special emphasize on MCH services.

**Laboratory Technicians:**

**80.** Services of one additional Laboratory Technician per FRU have been provided during Fy: 2009-10 This service is provided at 192 FRU's so as to strengthen the investigation facilities in these institutions. As of date 134 Lab technicians are working.

**Drugs and Consumables**

**Community Health Center:**

**81.** Karnataka has 324 CHC's out of which 140 are situated below the blocks/ Talukas. It is proposed to strengthen these CHC's with manpower & logistics to offer 24x7 services. Most of these CHC's are 30 bed hospitals. It is required to supply basic investigation consumables and drugs as per GOI specifications, RTI/STI drugs per CHC as per the specifications prescribed by the MOHFW, Govt of India. The brief details are as follows.

CHC drug kit for FRUs as per MOHW, GOI guidelines per CHC x 140CHCs
Urine testing strips (@ 1000 strips x 140 CHC
Drugs for RTI/STI (as per MOHW, GOI, NACO)
Resuscitation Kits

**First Referral Units:**

**82.** Karnataka has 192 FRU's. All these hospitals are providing Maternal & Child Health Services, treating RTI & STI cases and other services. It is required to supply basic investigation consumables. It is also proposed to supply drugs as per GOI guidelines as also RTI/STI drugs per FRU as per the specifications prescribed by the MOHFW, Govt. of India. The brief details are as follows.

FRU drugs as per MOHW, GOI 1 per FRU x 192 FRU's
Urine testing strips (@ 3000 Strips x 192 FRU's)
RTI / STI drugs as per MOHW, GOI, NACO)
Adult resuscitation kit and MVA syringes

**Outsourcing MCH services @ FRUs:**

**83.** There is acute shortage of specialists at FRUs. To obtain MCH specialist services at FRU , Santhamaranahalli FRU in Chamarajanagar district has been outsourced to NGO. On this basis those FRUs which are very difficult to operationalise during 2010-11 have been proposed for outsourcing MCH services to NGOs.

**84. Equipment:**

**i) Boyle's apparatus:** The facility survey of all the FRUs is completed and the requirement per facility has been taken. According to which 50 FRUs have to be provided with Boyle's apparatus. This has been evaluated on a need base per FRU.

**ii) Adult resuscitation kits: Will be procured under ARS funds.**

**iii) Setting up of Blood Storage Centers at FRU's :**

It is proposed to set up 60-blood storage center at FRU's, along with the existing 54 blood storage unit, which are situated at block level hospitals. The FRUs which are not having blood storage units are made functional with blood bank linkage.

The brief details are as follows:

a. Blood Storage Center Refrigerator with Thermograph (@ Rs. 0.65 L x 60)
b. Table top Centrifuge (@ Rs. 0.06 L x 60)
c. Insulated Cold Blood unit transfer boxes (@ Rs. 0.05 L x 60)
d. Air Conditioner-1ton (@ Rs. 0.25 L x 60)
e. Binocular Microscope (@ Rs. 0.25 L x 60)
f. Furniture (@ Rs. 0.25 L x 60)
g. Consumables & Re-agents désinfectants (@ Rs. 0.25 L x 60)

**85.** Further it is proposed to provide budgetary support for the FRU's which were proposed during previous years with consumables.

**86. Generator:** FRU and CHCs are conducting deliveries round the clock. It is required to provide uninterrupted power supply Hence it is proposed to supply one generator on a need based assessment.

**87. Blood Line (Rakta vahini):** PPH is the commonest cause of maternal death in Karnataka. To overcome the shortage of blood, the districts are conducting voluntary blood donation camps. In spite of this, districts are facing shortage of blood. Hence, Government of Karnataka has launched a program called Blood line (Rakta vahini) under the PPP initiative with TTK Group for 6 C category, Charamarajanagar and Bellary districts. The required bottles of blood are given free of cost to the beneficiaries and distributed to the backward districts.

**88. Haemoglobinometer : to be purchased on a need base through the ARS**

**89. Oxygen concentrator:** It is required to provide availability of oxygen services for the mother and neonates. It is difficult to refill the oxygen cylinders at the FRUs in the field. The oxygen concentrator supplied earlier has been found useful.

Sl. No.	Name of the District	No. of Units	Unit cost of Packed cell	Total
1	Gulbarga	1200	600	7.20
2	Koppal	1200	600	7.20
3	Bidar	1200	600	7.20
4	Raichur	1200	600	7.20
5	Bijapura	1200	600	7.20
6	Bagalkote	1200	600	7.20
7	Chamarajanagar	1200	600	7.20
8	Bellary	1200	600	7.20
	<b>Total</b>			<b>57.60</b>

**Abortion:**

**90.** In Karnataka, abortion accounts for 1% of maternal deaths (department data). There may be under reporting as illegal abortions and those conducted by unauthorized providers goes un reported. Management of un wanted pregnancy through early and safe MTPs as envisaged under the MTP act, is an important component of RCH 2. In Karnataka there are a total of 517 centers recognized for performing MTPs. Out of this, 436 are by the government and 171 are private institutions. It is proposed to make all the 24 x 7 PHCs functional for performing MTPs by providing MTP equipment kits to all the PHCs and MVA training to all the doctors including the doctors on contract. All FRUs are to have blood storage facilities as a backup for MTP emergencies.

**91.** Efforts are being made to provide for the unmet need of safe abortion services and to improve utilization of existing facilities so as to make safe abortion services accessible to all women in the rural areas.

- Training of medical personnel in MTP technique.
- IEC activities
- Procurement of MVA: The MVA is a safe abortion technique, if implemented properly will reduce unwanted pregnancies and in the process will reduce the MMR and morbidity to a significant extent and the need to adopt some method of contraception (*procured from ARS at FRU / PHC level*).
- MO's from 24 x 7 PHCs / CHC and FRU are trained for 12 days and placed in the same institutes to provide the necessary services. Training is done at indefied hospitals with good case load as per the GOI guidelines.

- Since 2006, 237 doctors are trained and placed and provided with the equipment.

### **Monitoring and evaluation:**

All the programme officers at District level will be made nodal officer of one taluka. They will monitor FRUs, 24x7 PHCs and all other programmes of NRHM.

- Every officer to visit at least 10 PHCs of 24 x 7 in a month and all FRUs and guide MOs in detail to provide remedial actions for each PHC not conducting more than 10 deliveries in a month and to make all the FRUs functional. (Incentive of Rs. 1000/- pm for all THOs)
- At the state level the programme officer are made the nodal officer of one district who will monitor all the programmes under NRHM. (Incentive of Rs. 5000/- pm for all the Nodal Officers)

### **RTI/STI**

**92.** Sexually transmitted infections / Reproductive Tract Infections pose a grave threat to women's life. A person with STI / RTI is 10-15 times more at risk of acquiring HIV. Majority of STI / RTI are treatable but not HIV. Hence the present focus of National AIDS control program is provision of STI /RTI services at all levels of health care. Early detection and treatment of common reproductive tract infections will be a component of essential care through the existing primary health care infrastructure. The necessary drugs are provided by the department of Health & Family Welfare. NACO assists the state in the following areas.

- a) Training of MO, Staff nurse, and Lab technicians in RTI/STI .
- b) Training of ANMs, AWW to identify and refer suspected cases of RTI / STI partner notification / referral to be mandatory
- c) The Training of lab technicians will be imparted for diagnosing the various infections. Wet mount for diagnosis at health facilities
- d) Privacy and full treatment as per the GOI Protocols. Partner treatment to be made mandatory.  
Apart from provision of STI/RTI services screening of all pregnant women for Syphilis and HIV, referral linkages to ICTC, linkages between STD, ICTC, ART and HIV TB is to be done. Positive persons are to be linked to Drop in center and community care center. **RTI /STI drugs will be supplied free of cost from GoI. The budget provision is made for consumables and equipments.**
- e) MO, Staff Nurses and Lab Tech are trained as per the GOI norm using the training manuals developed by NACO and trained at Regional Resource Centre with trained faculty.
- f) Health workers are sensitized for 2 days under RTI/STD for creating awareness among the community.
- g) Since 2008, 90 doctors and 30 lab tech from STI clinics, 1405 staff nurses and 499 lab techs from 24x7 PHC's are trained by the KSAPS.

## Maternal Death Audit:

- 93.** This helps to examine each maternal death as a sentinel event. It reviews all the health care interactions between a woman and health personnel prior to her death; providing a timeline of health-seeking actions and corresponding care provision across the health system. Assessment of health care through three dimensions: i) clinical performance (delays, omissions, and compliance with quality standards compared to established guidelines) ii) internal hospital organization and iii) continuity of care between health care facilities.
- 94.** Deputy Commissioners in their districts shall audit all maternal deaths. All the DCs have been sensitized. It is proposed to provide expenses towards conducting such meetings with spouses/relatives. To facilitate their presence, it is proposed to extend cash assistance Rs. 300/- for their transport & refreshment. Through this process of review, those crucial interventions are focused that, if provided in an expeditious manner, can avert future maternal deaths. It enables to shift their focus from a medical cause of death to a managerial perspective of missed opportunities.
- 95.** To encourage public, Anganwadi worker or ASHA to inform maternal deaths so as not miss such deaths occurring in their areas, it is proposed to extend cash assistance of Rs 500 to the first informant (out side the Dept.) for reporting a death. ASHA and ANM are trained to differentiate maternal deaths from other deaths Focused Group Discussions on maternal deaths is organized during the VHNDs.

## DEMAND DRIVEN STRATEGIES

### Janani Suraksha Yojana:

- 96.** The flagship program of Government of India to extend financial assistance to BPL mothers during 1<sup>st</sup> and 2<sup>nd</sup> live births During Fy:2010-11 the beneficiaries under this scheme could be approximately 4.8 lakhs

The brief details are as follows:



Projected total no, of Deliveries during financial year 2010-11	10.00 lakhs
Approximate No. of BPL (67%)	6.7 lakhs
Approximate deliveries with 1 <sup>st</sup> and 2 <sup>nd</sup> child (71.5%)	4.8 lakhs
Approximate no. of LSCS (10% of 4.8 lakhs)	0.48 lakhs
Approximate no. of urban deliveries (30% 4.32 lakhs)	1.3 lakhs
Approximate no. of Rural institutional deliveries	2.5 lakhs
Approximate no. of rural and home deliveries	0.5 lakhs

### **Drawing a Micro-birth Plan for each Beneficiary**

The following set of simple actions including a time-line for each of the activities leading to sanctioning of benefits and postnatal care for each expectant mother is the key to efficient implementation of the Scheme. The Registered ASHA or an equivalent worker would be responsible for drawing a micro-plan and organizing obstetric care to the registered JSY beneficiary.

<b>Sl. No</b>	<b>Activity</b>	<b>To be undertaken by</b>	<b>Proposed time</b>
1.	Identification and registration of beneficiaries and filling up of the Thai Card (including completion of formalities for receiving JSY, Prasooti Arike and Madilu benefits)	ASHA / ANM	< 12 weeks
2.	Preparing the birth plan including the dates of ANC and record it on Thai card and inform the mother.	ANM in presence of ASHA	3 months before EDD
3.	Motivating for institutional delivery	ASHA / ANM	4-6 months of pregnancy
4.	Identify the health center for referral as well as the place of delivery	ANM / MO, PHC	Before 2 weeks of expected date of delivery

5.	Taking necessary steps toward delivery as well as to make available fund to ANM/Health worker/ASHA etc.	MO, PHC	Before 2 weeks of expected date of delivery
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**ASHA package under JSY:**

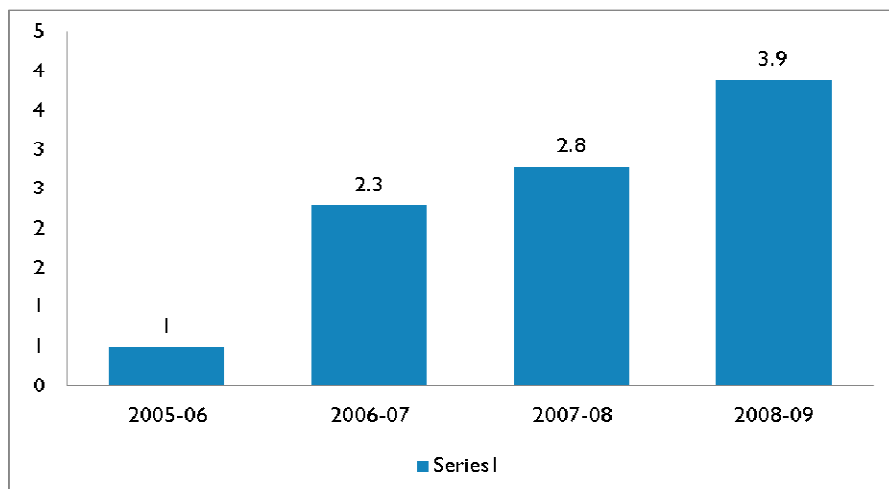
Rs.200/- for delivery as a package for ASHA is budgeted under JSY for all the districts. In the following 3 districts namely Kodagu, Chamrajnagar and Mysore sum of Rs. 600/- is provided as the package for ASHA for deliveries conducted in the ST category.

ASHA package for postnatal care is Rs. 50/- per case.

Government order has been issued on 20-05-2009, making 48 hours of stay mandatory after normal delivery. Instructions are already given to disburse the amount through cheque. The program is regularly monitored by the District Health Society. Private Nursing homes have been identified for providing JSY services

## Diagram-5

### Improvement in JSY beneficiaries over the years:



### Thayi Bhagya:

97. This is modeled on the Chranjivi model of Gujarat. Despite in sourcing of specialists and hiring specialists at the FRUs, Karnataka is experiencing shortage of specialists particularly in the field of obstetrics, anaesthesia and paediatrics. At the same time the private medical sector has a strong presence offering above services. To tap this resource, as a public private partnership, it is proposed to recognize some of the private hospitals in 6 'C' and Chamarajanagar districts, which have poor MMR and IMR parameters.

#### Conditions:

- Scheme for BPL women of age more than 19 years, for first two live births and who have regular ANC checkups.
- Private providers are empanelled in the identified districts to provide the delivery care package.
- The private providers to be screened by District Health Society so as to be sure of the facilities being provided for emergency obstetric care in their facilities.
- Private providers are reimbursed Rs.3,00,000 for every 100 deliveries on a capitation basis i.e.Rs.3000/- per delivery, out of which Rs.250 + Rs.75/- will go to transportation charges of the beneficiary and accompanying person.
- This scheme is extended to Government institutions up to FRU level. Rs.1,50,000 for 100 deliveries will be paid as a package for Government hospital i.e. Rs.1500/- per delivery. The break up of Rs.1500/- is as follows:

Rs.575/-	- ARS of the institution
Rs.300/-	- Doctor, who conducts delivery
Rs.200/-	- Staff Nurse, who assist delivery

Rs.100/- - cleaning staff.

Rs.250/- + 75/- - for transportation charges of the beneficiary and accompanying person.

For Government institutions a threshold is fixed on the basis of number of deliveries conducted. Only for the deliveries above the threshold level, this package is applicable.

Progress of the scheme up to the end of December 2009 is as follows.

Total number of MOUs signed in Pvt. Sector: 76

Total number of MOUs signed in Govt. sector: 32

Total number of beneficiaries covered under Thaiy Bhagya: 21020 (up to December 2009)

### **Prasuthi Araike:**

**98.** To encourage rest, nutritious food and medical care during first and second live births for BPL mothers, Karnataka has extended financial assistance to all the Government institution deliveries. The programme provides an assistance of Rs. 2000/- (Rs.1000/- during third trimester, and second installment immediately after delivery). The budget of Rs. 94.6 crores will be met out by the State budget for the year 2010-11.

The progress of the program as on December 2009 is – 1.58 lakhs.

### **Madilu: (Post natal care kit for BPL & SC/ST women in the state)**

**99.** To reduce the MMR and IMR and to improve institutional deliveries, Government of Karnataka has launched this New programme on Maternal Health called “MADILU” on 1st October 2007. The aim of the Madilu programme is to provide a Post-natal kit to the delivered mother, which contains the components for mother and the new born baby like bedspreads, soaps and detergents etc. Mosquito nets are also supplied to the Malaria endemic districts. **Beneficiaries are** BPL mothers who deliver in Government Institutions & is restricted to first two live births. Madilu products are procured from Government of Karnataka undertaking organizations i.e. Karnataka Handloom Development Corporation and Karnataka Soap and Detergents Ltd and mosquito nets are purchased under DGS&D rate contract.

To ensure quality of Madilu Kits, a State and District Level committee has been formed. The committee will inspect the quality of Madilu Kits before distribution.

## COMPONENTS OF MADILU KIT



Checks Bed Sheet



Jamakhana



Bed Sheet



Towel



Sweater, Socks  
and Cap



Jabla



Rubber Sheets



Abdominal Belt



Sanitary pads for  
mothers



Child Bed sheet



Flannel Bed Sheet



Cotton Diaper



Soaps and Detergents Kit



Mosquito Net (For 21 Malaria  
Endemic Districts Only)

### Physical Progress of Madilu Programme:

Period	Physical			
	Gen	SC	ST	Total
15th Sep-07 to 31st March 2008	9168	3877	2143	15188
01st April-08 to March-09	123360	47403	24378	195141
01st April-09 to Nov-09	118186	44365	21558	184109
<b>Total</b>	<b>250714</b>	<b>95645</b>	<b>48079</b>	<b>394438</b>

### Awards:

**100.** To encourage the field staff working at PHC, General Hospitals, CHC's and at District Hospitals it is proposed to institute awards to various categories of staff. Brief details and budget requirement are as follows:

- a) ANMs – awards for best ANM per Taluka for 175 Taluka/best ANM per District for 29 districts/ for best ANM for State
- b) Staff Nurse(PHC): Best Staff Nurse working at PHC per Taluka for 175 Talukas/Best Staff Nurse per District for 29 districts/ Best Staff Nurse per State
- c) Best Staff Nurse( CHC) per Taluka for 175 Talukas/ Best Staff Nurse per District for 29 districts/ Best Staff Nurse per State
- d) Best Doctor (working at PHC/CHC/GH
- e) Best Specialists (OBG, Pediatrics & Anesthetist) : one each at FRU/DH.

### Anaemia – Pilot Project :

#### Goal & Objectives

**101.** To demonstrate sustainable approaches and strategies to reduce prevalence of anemia in vulnerable groups in select districts of Karnataka over a three year period.

- To conduct a situational assessment of the problem and response to anemia in pregnant women, young children and adolescents in select districts of Karnataka.
- To train women in SHGs and VHSC members to identify vulnerable groups in their community with anemia.
- To enable the ASHAs and Anganwadi teachers to develop concrete individual tracking mechanisms to follow up all pregnant women with anemia and link them with necessary services including treatment, prevention measures such as deworming, IFA prophylaxis, nutrition and diet etc. treatment, in the PHC.

- To demonstrate sustainable mechanisms for the community based institutions (SHGs, VHSC and GP) to develop appropriate local responses to anemia in their communities
- To screen all adolescent girls between 10-19 years for anaemia.

### Geographic locations for the pilot

**102.** The project will be in 3 different locations in 3 districts, and will be introduced in a phased manner. Three districts will begin in year 1, followed by the other 3 in year 2. The Primary Health Centre (PHC) will be considered as the basic unit of intervention for the pilot project. All villages under the selected PHCs will be covered in the program.

**Table-14**

District	Taluk	No. of villages	PHCs	GPs
Bidar	Aurad	130	9	30
Chamrajnagar	Kollegal	103	16	37
Chitradurga	Molkalmuru	89	3	16

Total project period – 3 years

### **103. Iron Sucrose:**

In Karnataka iron deficiency anaemia in pregnant women as per NFHS-3 is 59.9% as compared to 48.6% in NFHS -2. Anaemia is a major contributing factor for maternal morbidity and maternal mortality. It is also associated with poor fetal out come

Oral iron and intramuscular iron have been used but it is not possible to achieve the target rise in the Hb level in a limited time period when the patient is approaching full term. Hence to improve the anemia it is proposed to provide iron sucrose to the anemic women which is able to raise the Hb to satisfactory level when used in severely anemic women .

#### **Iron sucrose is safe and effective alternative to oral iron**

It is proposed to be taken up as a pilot in Bangalore Medical College and Research Institute.

Severe anemia I.e. less than 7 gm hemoglobin in pregnant women will be identified and treated.

**Table-15**

<b>Status of FRU Operationalization</b>		
<b>Total No. of FRUs planned till 2010</b>	<b>Target 2009-10</b>	<b>FRU operationalized till Dec-09</b>
192	192	142
<b>Status of 24x7 PHCs</b>		
<b>Total No. 24x7 planned till 2010</b>	<b>Target</b>	<b>24x7 operationalized till 2009</b>
1200	1200	974

<b>Sl. No</b>	<b>Name of the Scheme</b>	<b>Type of Worker</b>	<b>Level of Facility (CHC/PHC/SC)</b>	<b>Amount of Incentive (Rs. Per month)</b>	<b>Performance expected</b>
1	Rent for SC	ANM	SC	1000	Stay at HQ
2	Remote area allowances (Most)				
		MO	PHC	10000	Stay at HQ
		SN	PHC	3000	Stay at HQ
		BHEO	PHC	800	Stay at HQ
		Paramedical Ophthalmic Assistant	PHC	750	Stay at HQ
		LHV	PHC	750	Stay at HQ
		Sr. Health Inspector	PHC	750	Stay at HQ
		ANM	PHC	600	Stay at HQ
		Lab Technicians	PHC	500	Stay at HQ
		Male Health workers	PHC	500	Stay at HQ
		Pharmacist	PHC	500	Stay at HQ
		Group 'D'	PHC	400	Stay at HQ
3	Remote area allowances (More)				
		MO	PHC	2000	
		SN	PHC	1500	Stay at HQ
		BHEO	PHC	400	Stay at HQ
		Paramedical Ophthalmic	PHC	375	Stay at HQ

		Assistant			
		LHV	PHC	375	Stay at HQ
		Sr. Health Inspector	PHC	375	Stay at HQ
		ANM	PHC	300	Stay at HQ
		Lab Technicians	PHC	250	Stay at HQ
		Male Health workers	PHC	250	Stay at HQ
		Pharmacist	PHC	250	Stay at HQ
		Group 'D'	PHC	200	Stay at HQ
4	Tribal Area allowance	MO	PHC	2000	To give service to Tribal area
		SN	PHC	1000	
		ANM	PHC	750	
5	Mobility Support	MO	PHC	500	Monitoring and evaluation
		LHV	PHC	300	
		ANM/MHW	PHC	200	
		THO	Taluka	750	
		District Programme officer	Dist.	1000	
		Nodal officer	State	5000	
		Sr.H.I./ BHEO	PHC	300	
6	EmOC & LSAS trained MBBS drs.	Trained MBBS drs.	FRU	10000	To give Emoc Services
7	Awards	MO	Taluk level	10000	To increase motivation which in turn increases the outcome of the programme
		MO	District Level	20000	
		MO	State Level	30000	
		Specialists	District Level	10000	
		Specialists	State Level	25000	
		SN	Taluk / District level	7500	
		SN	State Level	15000	
		ANM	Taluk level	5000	
		ANM	District Level	7500	
		ANM	State Level	10000	

#### Status of Anaesthesia Training

No. of medical colleges conducting LSAS training	No. of district hospitals conducting LSAS training	Total No. of MBBS doctors to be trained in LSAS till 2010	Target for 2009-10	No. trained till December 2009	No. of trained MOs posted at FRU till December 2009
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<b>4</b>	<b>24</b>	<b>108</b>	<b>44</b>	<b>18</b>	<b>67</b>
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**Table-16**

**Status of EmOC Training**

<b>No. of medical colleges conducting EmoC training</b>	<b>No. of district hospitals conducting EmoC training</b>	<b>Total No. of MBBS doctors to be trained in EmoC till 2010</b>	<b>Target for 2009-10</b>	<b>No. trained till December 2009</b>	<b>No. of trained MOs posted at FRU till December 2009</b>
<b>1+2</b>	<b>10</b>	<b>108</b>	<b>40</b>	<b>16</b>	<b>40</b>

**Table-17**

**Status of SBA Training**

<b>No. of districts conducting SBA training</b>	<b>No. of district hospitals / institutes practicing SBA protocols particularly partograph</b>	<b>No. of master trainers trained (Both State &amp; Districts)</b>	<b>No. of SNs/ANMs/LHVs to be trained till 2010</b>	<b>Target for 2009-10</b>	<b>No. trained till December 2009</b>
<b>29</b>	<b>42</b>	<b>254</b>	<b>8900</b>	<b>2000</b>	<b>4732</b>

**Table-18**

**Status of MTP Training**

<b>No. of doctors planned to be trained in MA/MVA/EVA till 2010</b>	<b>No. trained till December 2009</b>	<b>No. of 24x7 PHCs providing safe Abortion Services</b>	<b>No. of DH/FRUs providing comprehensive safe abortion services</b>
<b>350</b>	<b>140</b>	<b>140</b>	<b>143+24</b>

**Table-19**  
**Budget for Maternal health**

Sl. No	Component	Unit cost	Amount (Rs. in lakhs)
1	Monitoring: Mobility support at sub center to the ANM	Rs 200 pm for 8143 sub centers	508.00
2	Monitoring: Mobility support for PHC,MOH	@ Rs 500 pm for 2193 PHCs	
3	Monitoring: Mobility support for LHV	@ Rs 300 pm	
4	Monitoring: Mobility support for Male Health Worker	Rs. 200/- pm	
5	Monitoring: Mobility support for Senior Health inspector / BHEO	Rs.300/- pm	
5	Monitoring: Mobility support for THOs	Rs. 750/- pm	
6	Monitoring: Mobility support for District Nodal Officers	Rs. 1000/- pm	
7	Monitoring: Mobility support for State Nodal Officer	Rs. 5000/- pm	
8	Difficult area allowance for Medical officers and para medical staff.		512.42
12	Award for best Specialists / MOs / SNs/ ANMs		50.00
10	Rent for sub center	@ Rs 1,000 pm	273.84
11	Maternal death audit. For reporting and conducting meetings	Rs. 800/- per case	10.6
12	JSY -		4602.58
12	Asha incentive for MH services (non JSY)		
13	Madilu		2800.00
14	Thayi bhagya		1000.00
15	Drugs and supplies at SC	237.00	1229.56
16	SSD Kits at SCs	75.00	
17	Drugs and supplies at PHC	247.75	
18	Drugs and supplies at CHC	195.00	
19	Drugs and supplies at FRU	332.81	
20	Anaemia – Iron sucrose pilot study	24.00	
21	Misoprostol	63	
22	RTI / STI	55	

24	Generator for CHC/FRU	484	831.40
25	Boyles apparatus for 50 FRUs	125	
26	Blood storage center at FRU	139	
27	Oxygen concentrator	83.4	
29	Contracting specialists	@ Rs 50,000 per FRU for 75 FRUs	450.00
30	Incentive for EmOC & LSAS trained doctors	@ 10000/ pm	96.00
31	ANM for the vacant position	@ Rs 6000 pm for 12 months	496.80
32	2 <sup>nd</sup> ANM sub center in 7 C category districts	@ Rs 6000 pm 750 ANMs	535.68
33	Contractual doctor for the PHCs/FRUs - Need based	@ Rs 25,000 pm	531.00
34	Contractual staff nurses at PHCs / SCs against ANM Vacancy	@ Rs.7000/- pm	3822.00
35	Staff nurses @ 2 per CHC for 150 CHCs	@ Rs.7,000 pm	
36	Staff nurses at FRU 2 staff nurses for 192 FRUs	@ Rs.7,000 pm	
37	134Lab tech at FRU's	@ 6500 pm	104.52
38	Assistant to staff nurse at 24x7	1200 PHCs	ARS
40	Out Sourcing of FRUs		10.00
41	Blood Line		57.60
42	ICTC		249.28
43	Yashaswini coverage (HIV+ve pregnant women)	@ Rs 6,000 For 1000cases	60.00
44	Tayi Card		80.00
45	Printing of Registers, Case Sheets and Referral Slips		40.00
46	Anemia Pilot study		269.64
	<b>Total</b>		<b>18620.92</b>

## CHAPTER -7

### CHILD HEALTH

#### **Background:**

**104.** Karnataka has a special interest and commitment to the health and well being of children during their intrauterine period, infancy, toddler years, school age and adolescence. Its interventions reach out through Maternal and Child Health programmes through its public health system, Anganawadis, ASHAs and through schools.

**105.** Mortality rates are good indicators of health and health care in different countries. Infant Mortality rate is universally regarded as an important indicator of, health and also the level of living of people in the community and effectiveness of MCH services in particular. As per the UNICEF 2007 report the main causes of Infant Mortality and under five mortality is depicted below:

**It is reported that the common causes of Neonatal deaths in Karnataka are as follows:**

<b>Causes of Neonatal deaths</b>	<b>%</b>
Preterm	35%
Infection	24%
Asphyxia	23%
Congenital	6%
Others	6%
Diarrhea	2%

To reduce IMR from present 45/1000(SRS 2008) live births to 30 by the year 2010

To reduce Neonatal Mortality from 40/ 1000 live births to 25 by the year 2012

To increase exclusive Breast feeding to 90% by 2012

106. Many of the Millennium Development Goals are either directly or indirectly related to Health and Nutrition. And MDG 4 is to reduce the child mortality by 2/3 of 1990 by 2015.

**Present Status and Goals**

Health Indicators	Current Status NFHSIII	Current Status DLHS	Goals		
			2008-09	2010	2012
IMR	43/1000LB 45(SRS2008)		35/1000LB	30/1000LB	25
Fully immunized	55%	78%	80%	90%	99%
Diarrhea taken for treatment	64.8%		80%	90%	100%
Diarrhea treated with ORS	31%	40%	60%	70%	80%
ARI taken for treatment	78.9%	75.8%	90%	100%	100%
Know about danger signs		20%	50%	70%	90%

**Situation analysis:**

Component	NFHS I	NFHS II	NFHS III	DLHS
IMR per 1000 live births	65	52	43 (SRS2008-45)	
IMR URBAN / 1000 live births	60	40	37	
IMR RURAL / 1000 live births	68	57	47	
Fully immunized %	52%	60%	55%	85%
Diarrhea taken for treatment %			64.8%	
Diarrhea treated with ORS			31%	40%

%				
ARI taken for treatment %			78.9%	75.8%

**107. Objectives:**

- To promote safe deliveries
- To promote Neonatal care starting from home to health facility
- Provision of madilu kits for early Neonatal and Maternal care
- Ensure early Breast feeding & exclusive Breast-feeding for 6 months
- Complete primary immunization by age one year to 100%
- To reduce child malnutrition levels
- Create awareness for care seeking for sick neonate in early stages
- Promote use of ORS in diarrhoea along with Zinc supplementation
- To provide Tertiary care for the needy children

**Strategies:**

**108.** Following interventions are planned comprehensively to improve the child health services in turn which will have a bearing on reducing the infant mortality in Karnataka for FY: 2010-11:

**109. Home Based Newborn and Child Care (HBNCC):**

Karnataka is empowering the grass root level health workers i. e. ASHAs for Home Based Newborn and Child Care by focusing on mother and newborn child. Hence, it has been decided to implement, Home Based Neonatal and Child Care in 16 taluks of 7 C category districts namely Bidar, Gulbarga, Yadgir, Raichur, Koppal, Bijapur, Bagalkot and Chamrajnagar through 3623 ASHAs. Recently the Dept. of Health & Family Welfare Services has entered into an agreement with SEARCH, Gadchiroli, Maharashtra, who have developed a much acclaimed research based curriculum with proven results in reducing IMR through HBNCC. The program will be implemented through series of training for different cadres of health workers. The training of ASHAs is expected to be completed by November 2010 in phases, however interventions will commence immediately after first phase of training. It is proposed to provide basic medicines and other logistics such as Cotrimoxazole, Amoxicillin, Paracetamol paediatric suspension, Digital thermometer, Weighing scale and other consumables.

**110. Goals and objectives of HBNCC:**

The goal is to accelerate reduction in neonatal, infant and child mortality rate in Karnataka by implementing HBNCC to provide effective newborn and child care to the rural and tribal population.

**111. Specific objectives:**

Train grass root health functionaries such as ASHAs and ANMs in HBNCC. Strengthen the training, supervision and community mobilization part of the ASHA scheme.

Deliver HBNCC services in the selected population through ASHAs and ANMs  
Reduce Neonatal Mortality Rate by the end of 3 years by more than 40% of its existing

level in the selected taluks.

Create a pool of trainers for use during the state wide scaling up of the HBNCC.

### **112. Components and interventions:**

All the interventions under the HBNCC have been included with modifications based on the local needs. The key components of HBNCC are, Co-operation of community – information for use of HBNCC, enlisting women eligible to become pregnant and pregnant women and updating it regularly, Health education, Encourage institutional delivery, Attending home delivery, Initiation of early and exclusive breast-feeding, Thermal care of the neonate at home, Assessing neonates for high-risk status, and to monitor the baby for any infection. Further, early diagnosis and treatment of neonates with sepsis, and referral, weekly weighing, problem solving, advising and helping mother, Referral of very sick neonates when necessary, Vital statistics and HBNCC service data monitoring are the other components.

### **113. Facility Based Neonatal Care (FBNC):**

Serious and concerted efforts have to be made to address the needs of a newborn in its first days in order to reduce Neonatal Mortality in Karnataka. While simple known, preventive and promotive interventions within the home environment such as exclusive breast-feeding or keeping the baby warm, remain the vital factor in tackling newborn mortality, Provision and delivery of services in the existing health facilities at the District Hospitals, FRUs/CHCs and PHCs for both essential newborn care and care for sick newborns needs strengthening. The recommendations relate to the services, design, infrastructure, equipments, supplies and human resource requirement for providing newborn care at selected health facilities

The guidelines issued by MoHFW, Govt. of India/ UNICEF (Toolkit for setting up special care Newborn Unit, Stabilization Units and Newborn Care Corners at District Hospitals, FRU's /CHC and PHCs) will be referred and, based on the availability of space and existing infrastructure, equipments and consumables will be supplied for strengthening FBNC

### **114. Sick Newborn Care Unit (SNCU):**

The Sick Newborn Care Unit (SNCU) is a neonatal care unit in the vicinity of the labour room that provides care to all sick newborns (except for those requiring assisted ventilation or major surgery). It is proposed to set up SNCU at some of the District Hospitals, Women and Children Hospitals and at Govt. Medical College Hospitals.

It is proposed to set up SNCU at some of the District Hospitals, Women and Children Hospitals and at Govt. Medical College Hospitals. It is proposed to address requirement for equipment, supplies, training and human resources.

- a. District Hospital: Facility Based Newborn Care at 19 district hospitals Sick Newborn Care Unit (SNCU) - DH (@ Rs. 25.00 lakh / DH x 19 DH) = 475.00 lakhs
- b. Women & Children Hospital & General Hospital: Facility Based Newborn Care, Sick Newborn Care Unit (SNCU) - DH (@ Rs. 16.00 lakh/ WCH&GH x 15)= 240.00 lakhs
- c. Govt. Medical College Hospital (10) for Sick Newborn Care Unit (SNCU) for FBNC (@ Rs. 13.5 lakh x 10medical colleges) = 135.00 lakhs
- d. Indira Gandhi Institute of Child Health:

Indira Gandhi Institute of Child Health (IGICH) is an autonomous 230 bedded, child health care institute established by the Govt. of Karnataka, working on non profit basis. IGICH is offering multi speciality health care services exclusively for children from 0-18 years. The institute has PICU with Ventilator support, NICU with Ventilator support, Blood Bank, CT Scan, laboratory facilities etc. It is managing several high risk neonates from Karnataka and from neighboring states. The Indira Gandhi Institute of Child Health is willing to act as a nodal center for training of doctors, staff nurses and paramedics. Hence, it is proposed to extend assistance of Rs. 38.07 lakhs under NRHM for equipments / consumables

List of proposed SNCU's is available in Annexure - I.

#### **115. Stabilisation Unit:**

The Neonatal Stabilisation Unit is a facility within or in close proximity of the maternity ward where most sick and low birth weight newborns can be taken care of. All first Referral Units (FRUs) need to have a Neonatal Stabilisation Unit in addition to a Newborn Care Corner. Initially, it is proposed to set up Stabilisation Units at 73 FRUs / CHCs in 14 IMNCI districts. Initially, it is proposed to set up Stabilisation Units at 73 FRUs / CHCs in 14 IMNCI districts. It is proposed to address requirement for equipment, supplies, and training.

FRUs: Stabilisation unit - FRU (@ Rs. 1.00 lakh x 73 taluk hospitals in 14 IMNCI districts, excluding district headquarters.

The suggested equipments and renewable required for Stabilization Unit are as follows:

### Equipment and renewable required for a Stabilization unit

Item No.	Item Description
1	Open care system: radiant warmer, fixed height, with trolley, drawers, O2-bottles
2	Resuscitator, hand-operated, neonate, 500ml
3	Laryngoscope set, neonate
4	Scale, baby, electronic, 10 kg <5kg>
5	Pump suction, foot operated
6	Thermometer, clinical, digital, 32-34C
7	Light examination, mobile, 220-12 V
8	Hub Cutter, syringe
	Renewable Resources
9	I/V Cannula 24 G, 26 G
10	Extractor, mucus, 20ml, sterile, disposable Dee Lee
11	Tube, feeding, CHO7, L40cm, sterile, disposable
12	Oxygen cylinder
13	Tube, suction, CH 10, L50 cm, sterile, disposable
14	Cotton wool, 500g, roll, non-sterile, Sterile Gloves
15	Disinfectant, chlorhexidine, 20%

The list of 73 FRUs / CHCs for setting up Stabilization Units is given in Annexure – II.

- 116. Newborn Care Corner:** This is a space within the delivery room where immediate care is provided to all newborns. This area is MANDATORY for all health facilities where deliveries take place. The required equipment will be procured from the untied funds/ corpus grants available from the respective PHCs. The Newborn Care Corner will be set up at all 24x7 PHCs in the state.

The suggested equipments/ consumables for Newborn Care Corner are as follows;

Item No.	Item Description
1	Open care system: radiant warmer, fixed height, with trolley, drawers, O2-bottles
2	Resuscitator, hand-operated, neonate, 500 ml
3	Weighing Scale, spring
4	Pump suction, foot operated
5	Digital Room Temp. display with clock with display of seconds
6	Light examination, mobile, 220-12 V
7	I/V Cannula 24 G, 26 G
8	Extractor, mucus, 20 ml, Sterile, Disposable Dee Lee
9	Towels for drying and wrapping the baby
10	Sterile equipment for cutting and tying the cord (clamping)
11	Tube, feeding, CHO7, L40cm, sterile, disposable
12	Oxygen cylinder & Sterile gloves

#### Facility Based Newborn Care facilities

Health Facility	Facility	No. of units	All Newborns at Birth	Sick Newborns
24x7 PHCs	<b>Newborn Care Corner</b>	946	Newborn care corner in labour rooms	Prompt referral
CHC/ FRU	<b>Stabilisation Unit</b>	73	Newborn care corner in labour rooms and in operation theatres (OT)	Neonatal Stabilisation Unit and care of sick infants
District Hospital	<b>Sick Newborn Care Unit</b>	45	Newborn care corner in labour rooms and in operation theatres (OT)	Special Care Newborn Unit for care of sick infants

**IMNCI program:**

Integrated Management of Neonatal and Childhood Illnesses (IMNCI) program is an innovative approach for tackling the major diseases of early child hood with an integrated approach to ensure that all relevant needs of the are addressed. The IMNCI implementation was initiated on a pilot basis in Raichur districts from during 2005-06. The main components were training of health staff, ensuring a referral treating minor illnesses with supervision and monitoring, raising community awareness, initiation of early breast-feeding and others.

**The brief details of training progress in Raichur district:**

<b>Block</b>	<b>AAW trained</b>	<b>Total AWW</b>	<b>ANM trained</b>	<b>Total ANMs</b>	<b>Doctors trained</b>	<b>Total doctors</b>	<b>Nurses trained</b>	<b>Total Nurses</b>	<b>Total Trained</b>
Raichur	350	384	53	59	14	17	5	28	422
Manvi	312	372	37	45	13	22	2	24	364
Deodurg	290	423	31	40	9	18	2	25	332
Sindanoor	342	443	37	44	13	24	3	26	395
Lingsugur	287	399	38	43	16	23	2	28	343
<b>Total</b>	<b>1581</b>	<b>2021</b>	<b>196</b>	<b>231</b>	<b>65</b>	<b>104</b>	<b>14</b>	<b>131</b>	<b>1856</b>

The IMNCI program in Raichur dist. has resulted in reduction in actual no. of births, brief details of which are given below:

<b>Year</b>	<b>Population</b>	<b>Expected births</b>	<b>Deliveries</b>
2005	1817102	39976 (CBR 22)	37528
2006	1855936	40831 (CBR 22)	36703
2007	1895604	39808 (CBR 21)	35526
2008	1936123	40659 (CBR 21)	39037
2009 (till Sept.)	1977514	19775 (CBR 20)	19776

During Fy: 2006-07 & 2007-08 IMNCI program has been expanded to other eight districts i.e., Bidar, Gulbarga, Bellary, Gadag, Bijapur, Koppal, Chamarajanagar & Kodagu, including the pilot district of Raichur. Further during fy: 2008-09 it was proposed to undertake IMNCI training in the districts of Belgaum, Uttara Kannada, Dharwad, Haveri and Bagalkot. However training is under progress for the former 9 districts..

### **118. Infant Death Audit:**

As state is stepping up facilities, to bring down Infant Mortality Rate (IMR) from 45 (SRS 2008) to 30 by 2012, it is imperative to know the causes of infant death and how these could be avoided. UNICEF and ICMR has undertaken such proposed activity i.e. Infant Death Audit will help to take a decision based on evidence to optimize its efforts and resources audits in past. UNICEF will provide technical support to implementing this activity such as development of tool and protocols etc.

It is proposed to provide incentive for the Infant death informant, by a non-health dept. personal (@ Rs. 100/infant death) such as ASHA, Anganwadi worker, Community member etc. so that the issue of under reporting and causes of death are identified, so as to take corrective measures.

The program is proposed to be initiated during Fy: 2010-11 for confining to infant deaths. Later it will be upscale to include all the child deaths. The incentive for 1<sup>st</sup> informant of infant mortality will be given to the ASHA/ a community member. The infant deaths that are occurring in Public/ Private health care facilities shall not be given any incentive.

### **119. Infant and young child feeding (IYCF):**

Promotion of early initiation of breast feeding (as early as possible after delivery) and exclusive breast feeding till 6 months and timely complementary feeding with continued breast feeding for 2 years is the single most effective preventive intervention for child survival which is to be emphasized under infant and young child feeding.

If every baby were exclusively breastfed from birth for 6 months, an estimated 1.5 million lives would be saved each year. Not just saved but enhanced, because breast milk is the perfect food for a baby's first six months of life - no manufactured product can equal it as it is alone is the ideal nourishment for infants for the first six months of life as it contains all the nutrients, antibodies, hormones and antioxidants and other factors an infant needs to thrive. It protects babies from diarrhea and acute respiratory infections, stimulates their immune system and response to other diseases and to vaccination. Breastfeeding also has many health and emotional benefits for the mother, including decreased blood loss in postpartum period, delayed return to fertility, and decreased risk of cancer of the breast and ovaries.

In Karnataka, as per NFHS III, only 35.6% of children under 3 years are breastfed within one hour of birth and 58% of Children age 0-5 months were exclusively breastfed. So it will be prioritized to promote the breast-feeding practices at the earliest to enhance the knowledge among expectant mothers. From the DH&FWS, April to Sept 2009 has reported 481,099 and thus approximately 962,198 (~10,00,000) deliveries are to be estimated annually. Funds will be provided to the District Health Society for IEC activities, and to print and distribute brochure carrying messages on importance of breast-feeding practices at the time of delivery at hospitals for mother

IYCF will be prioritized to promote the breast-feeding practices at the earliest to enhance the knowledge among expectant mothers. From the DH&FWS data April to Sept 2009 has reported 481,099 and thus approximately 962,198 (~10,00,000) deliveries are to be

estimated annually. An information brochure carrying messages on importance of breast-feeding practices will be developed and distributed at the time of delivery for every mother. IEC, interpersonal communications skills will be imparted to ASHA for promoting breastfeeding. Regular review meetings will be organised. ASHA will provide service at the doorstep.

#### **120. Early detection and Management of diarrhoea, ARI and other infections:**

Diarrhea is usually a symptom of gastrointestinal infection, spread through contaminated food or drinking water, or from person to person as a result of poor hygiene. Severe diarrhea leads to fluid loss, and sometimes is life threatening, particularly in young children and those who are malnourished or have impaired immunity. Community studies indicate that every child below 5 years of age will have 2-3 episodes of diarrhea per year.

Recent scientific advances show that the number of deaths attributable to diarrhea can be drastically reduced through

- i. use of an improved ORS solution with reduced levels of glucose and salt (i.e. reduced total osmolarity) and
- ii. by use of zinc supplements.

Health-care workers treating children for diarrhea are encouraged to provide caretakers with two 1-litre packets of the new ORS, for home-use until the diarrhea stops.

#### **121. Use of zinc supplements:**

As per the guidelines of Govt of India, Health-care workers treating children for acute diarrhea are encouraged to provide caretakers with 20 mg per day of zinc supplementation for 10–14 days (10 mg per day for infants under six months old) to curtail the severity of the episode and prevent further occurrences in following 2-3 months. The administration of ORS and zinc supplements should be coupled with continued feeding (or increase frequency of breastfeeding) during the diarrhea episode.

Apart from reducing duration and severity of the treated episodes of acute diarrhea, zinc treatment in programmatic condition has the potential to decrease hospital admission rates by 15-20%, decrease child mortality by 3-5% and decrease the incidence of subsequent episodes of diarrhea and possibly pneumonia by 25% over ensuing 3 months. Addition of Zinc with ORS has been shown to substantially reduce the use of unwarranted drugs during acute diarrhea. This is likely to help reduce emergence of drug resistant enterobacteria, a major public health problem. Diarrhoea due to infections will be treated by supplementing with Cotrimaxazole/ Amoxicillin pediatric suspensions.

#### **122. Navjaat Shishu Suraksha karyakram (NSSK):**

Navjaat Shishu Suraksha karyakram (NSSK) a basic newborn care and resuscitation training programme has been launched to address newborn care at birth and to ensure the best possible support in life for the newborn. The objective of this initiative is to have one trained person in basic newborn care and resuscitation at every delivery. The training is based on the latest available scientific evidence and will be immensely useful in decreasing the neonatal mortality in the country. As per the letter from Joint Secretary,

Govt. of India, MoHFW, Nirman Bhavan, New Delhi- 108, Dt: 16-12-2009, six specialists have been deputed for the NSSK Masters Training program at NIHFW, Munirka, New Delhi –110067 on 23<sup>rd</sup> & 24<sup>th</sup> Jan 2010. Further, team of four specialists (@ two Gynecologists and two Child Specialists /district x 30 districts) have been identified already for further training at state level.

### **123. Nutritional Rehabilitation Centres (NRC):**

As per NFHS III, 41.1 percent children (under 3 years age) are underweight for their age. 38 percent children (under 3 years age) are stunted i.e. almost every third child is chronically undernourished. 17.9 percent of under 3 years children are wasted (too thin for height). Under-nutrition contributes to 53 percent of deaths in children of 0 to 5 years age group. (The Lancet, Vol 361, June 2003). Children with severe acute malnutrition (SAM) are near to death and hence require urgent medical attention coupled with nutritional rehabilitation to save their lives.

It is proposed to pilot at two District/ Medical College Hospitals. Under the scheme severely malnourished (Grade-3 & Grade-4) children identified by Anganwadi workers are proposed to be referred to Nutritional Rehabilitation Centres for management of malnutrition. Severely Malnourished children are treated as per the IAP Guidelines. It is proposed to train PHCs and CHCs Medical officers, Anganwadi teachers, Nursing Staff, Cooks in the district for management of malnutrition.

### **124. Tertiary care of sick Neonate at Medical college / Private institutions:**

The components of Child Health are designed to cater to the improvement in overall health for the children from the day it is born up to adolescent age. The inter linkage of each program will enhance the opportunity to promote the comprehensive health among children.

The major problems managed at NICU (Neonatal Intensive Care Unit) are:

1. Preterm babies for general preterm care
2. Preterm babies with complications like

- Respiratory distress syndrome
- Infections and sepsis
- Hyper Bilirubinemia
- Feeding Problems
- Convulsions
- Meconium aspirations syndrome
- Major and minor congenital anomalies

3. Term babies with

- Birth asphyxia
- Hyper Bilirubinaemia
- Infections and sepsis
- Convulsions
- Bleeding diathesis
- Congenital anomalies

Recently a state level consultative committee was held on 1st Dec 2009. The members from many of the Government and Pvt. Medical College Hospitals, Pvt. Neonatal care Hospitals, representative from Neonatology Forum of Karnataka have attended the discussion and have expressed keen interest to join hands in achieving the objectives of the NRHM to bring down IMR to the desired level. It is estimated that 10% of all neonatal illnesses need secondary and tertiary neonatal care for that better management and survival. It was mentioned that the cost of treatment in NICU could be approximately Rs. 1200 – 1500 / case, which would require an average of 5 days stay. It is proposed to provide NICU care services at CGHS rates and to reimburse the actual medicine expenditure. MOU will be signed between the Dept. of Health & Family Welfare and the hospitals who are willing to provide NICU care.

### **125. Prevention and management of Infant blindness in Karnataka under NRHM:**

Over one-third of the world's blind children live in our country. Childhood blindness in India accounts for a serious health problem. Retinal causes of infant blindness account for 22% of these causes. There is very limited governmental and Non-governmental action in this sphere. Several causes of infant blindness are preventable, of which the commonest cause is Retinopathy of Prematurity (ROP). It has been estimated that of the roughly 27 million annual live births in India, approximately 8.7% of newborns in India are < 2000 grams. This would imply that close to 2 million newborns are at risk for developing ROP and would require screening. The number of trained ophthalmologists capable of screening and treating ROP are very few in India.

After a series of discussions the Dept. of Health & Family Welfare through NRHM is implementing project and with the assistance of Narayana Nethralaya Postgraduate Institute of Ophthalmology (NNPIO) Bangalore, which envisages to screen and treat infant blindness including ROP in the 7 C category districts, which has higher IMR and MMR. A team of one Ophthalmologist and one ophthalmic assistant from each district are trained. A detailed presentation was made before Mission Director, Joint Secretaries, Assistant Commissioner, Child Health, NRHM, MoHFW, Govt. of India, New Delhi on 23<sup>rd</sup> Sept. 2009. The training of Ophthalmologist and Ophthalmic assistance and the process of equipment procurement is under progress.

#### **Project Objectives:**

1. To screen 'High Risk Babies' for ROP, using a tele-ophthalmology model already tested by NNPIO using a portable digital pediatric retinal camera by trained technicians.
2. The training will be conducted by NNPIO, free of cost.
3. To create a frame-work for referral and treatment of all infants with treatment grade ROP.
4. To collect community based data on ROP and infant blindness

#### **Project outcome:**

1. Total number of babies born < 2000 grams at birth will be screened for ROP: it is expected to screen 60%, 75% and 90% of LBWs during , 2010-11, 2011-12 and 2012-13 .

2. It is expected to treat at least 75% of ROP who require treatment during the project period.
3. It is expected to train and re-train the teams as per schedule.
4. It is expected to train at least one Ophthalmologist /district to be laser proficient for ROP. This skill can be used for a host of adult retinal problems including diabetic retinopathy.

During FY: 2010-11, it is proposed to extend this program to the Central Karnataka area consisting of five districts namely, Chitradurga, Bellary, Davangere, Haveri, Gadag and Dharwad. The NNPIO will extend its training and expertise free of cost. The brief details of movement of teams are as follows:

<b>Team No.</b>	<b>Day</b>	<b>From</b>	<b>To</b>	<b>Distance(Kms)</b>	<b>Screening site</b>	<b>Halt</b>
<b>Team I</b>	Monday	Raichur	Raichur	0	Raichur	Raichur
	Tuesday	Raichur	Gulbarga	176	Gulbarga	Gulbarga
	Wednesday	Gulbarga	Bidar – Gulbarga	228 (114 x2)	Bidar	Gulbarga
	Thursday	Gulbarga	Bijapur	145	Bijapur	Bijapur
	Friday	Bijapur	Bagalkot – Koppal	286 (88 + 198)	Bagalkot	Koppal
	Saturday	Koppal	Raichur	250	Koppal	Raichur
<b>Team II</b>	Monday	Davangere	Davangere	0	Davangere	Davangere
	Tuesday	Davangere	Chitradurga	128 (64+64)	Chitradurga	Davangere
	Wednesday	Chitradurga	Bellary	306(126 + 180)	Bellary	Davangere
	Thursday	Davangere	Haveri	69	Haveri	Haveri
	Friday	Haveri	Dharwad	93	Dharwad	Dharwad
	Saturday	Dharwad	Gadag	226 (76 + 150)	Gadag	Davangere

**Karnataka is the first state in the country to implement this ambitious project to handle the epidemic of infant blindness.**

The intervention also will enable the Eye surgeons to treat other ophthalmic conditions in the neonate and to the technology and equipment that are procured will be also useful to treat many pathological conditions of retina including diabetic retinopathy.

Brief details of budget provision under Child Health Program for Fy: 2010-11 is placed as annexure – III

**Annexure – I****List of proposed hospital for setting up SNCU**

<b>Sl.no.</b>	<b>Name of the Hospitals for setting up SNCU</b>
1	District Hospital, Gulbarga
2	District Hospital, Koppal
3	District Hospital, Bijapur
4	District Hospital, Bagalkot
5	District Hospital, Haveri
6	District Hospital, Gadag
7	District Hospital, Karwar
8	District Hospital, Chikmagalur
9	District Hospital, Madikeri
10	District Hospital, CH'nagar
11	District Hospital, Kolar
12	District Hospital, Tumkur
13	District Hospital, Chitradurga
14	District CG Hospital, Davangere
15	District Hospital, Chikballapur
16	District Hospital, Ramanagara
17	District Hospital, Dharwad
18	District Hospital, Yadgir
19	District Hospital, Udupi
20	Women & Children Hospital, Chikkamagalur
21	Women & Children Hospital, Lady Goshan W&CH, Mangalore
22	Women & Children Hospital, Udupi
23	Women & Children Hospital, Davangere
24	Women & Children Hospital, Gadag
25	Women & Children Hospital, Madikeri
26	Women & Children Hospital, Ranibennur
27	HSIS Ghosha Hospital, Shivajinagar, Bangalore

28	K.C.General Hospital, Malleshwaram, 5 <sup>th</sup> cross, Bangalore
29	General Hospital, Jayanagar, 4 <sup>th</sup> T Block, Blore
30	District Hospital, Bidar
31	District Hospital, Raichur
32	District Hospital, Shimoga
33	District Hospital, Hassan
34	District Hospital, Mandya
35	District Hospital, Belgaum
36	Cheluvamba Hospital, Mysore
37	Vanivilas Hospital, Fort, K.R. Road, Bangalore
38	KIMS Hospital, Hubli
39	VIMS Hospital, Bellary
40	Chituguppi Corp Maternity Hospital, Hubli
41	SMT Maternity Hospital, Mysore
42	Chamundi Maternity Hospital, Mysore
43	VV Mohalla Maternity Hospital, Mysore
44	Maternity Hospital Sedum, Gulbarga
45	Indira Gandhi Institute of Child Health, Bangalore

**Annexure: II****List of FRUs for setting up Stabilisation Unit**

<b>SLN o</b>	<b>District</b>		<b>FRU</b>	<b>SL No</b>	<b>District</b>		<b>FRU</b>
<b>1</b>	<b>Bidar</b>	<b>1</b>	Humnabad	<b>8</b>	<b>Bagalkote</b>	<b>41</b>	Badami
		<b>2</b>	Balki			<b>42</b>	Mudhol
		<b>3</b>	Basavakalyana			<b>43</b>	Bilagi
		<b>4</b>	Aurad			<b>44</b>	Hunagund
<b>2</b>	<b>Gulbarga</b>	<b>5</b>	Afzalpur			<b>45</b>	Jamakhandi
		<b>6</b>	Aland	<b>9</b>	<b>Dharwad</b>	<b>46</b>	Kalghati
		<b>7</b>	Chittapur			<b>47</b>	Navalgund
		<b>8</b>	Jevargi			<b>48</b>	Kundgol
		<b>9</b>	Chincholi	<b>10</b>	<b>Gadag</b>	<b>49</b>	Laxmeshwar
		<b>10</b>	Shourapur			<b>50</b>	Nargund
		<b>11</b>	Sedam			<b>51</b>	Ron
		<b>12</b>	Shahpur			<b>52</b>	Mundargi
		<b>13</b>	Yadgiri	<b>11</b>	<b>Haveri</b>	<b>53</b>	Shiggon
<b>3</b>	<b>Raichur</b>	<b>14</b>	Sindnur			<b>54</b>	Ranibennur
		<b>15</b>	Lingasur			<b>55</b>	Hirekerur
		<b>16</b>	Devadurga			<b>56</b>	Savanur
		<b>17</b>	Manvi			<b>57</b>	Bydagi
<b>4</b>	<b>Koppal</b>	<b>18</b>	Kushtagi			<b>58</b>	Hanagal
		<b>19</b>	Gangavathi	<b>12</b>	<b>Uttara Kannada</b>	<b>59</b>	Sirsi
		<b>20</b>	Yelburga			<b>60</b>	Kumta
<b>5</b>	<b>Bellary</b>	<b>21</b>	Sandur			<b>61</b>	Mundgod
		<b>22</b>	Hospet			<b>62</b>	Honnavar

		<b>23</b>	Hadagalli			<b>63</b>	Halliyal
		<b>24</b>	Siriguppa			<b>64</b>	Siddapur
		<b>25</b>	Hagaribommanahalli			<b>65</b>	Yellapur
		<b>26</b>	Kudligi			<b>66</b>	Joida
<b>6</b>	<b>Balgaum</b>	<b>27</b>	Athani			<b>67</b>	Ankola
		<b>28</b>	Bailahongal			<b>68</b>	Bhatkal
		<b>29</b>	Khanapura	<b>13</b>	<b>Kodagu</b>	<b>69</b>	Virajpet
		<b>30</b>	Chikkodi			<b>70</b>	Somavarpet
		<b>31</b>	Gokak	<b>14</b>	<b>Chamarajanagar</b>	<b>71</b>	Yelandur
		<b>32</b>	Soundatti			<b>72</b>	Kollegal
		<b>33</b>	Hukkeri			<b>73</b>	Gundlupet
		<b>34</b>	Raibag				
		<b>35</b>	Ramdurg				
<b>7</b>	<b>Bijapur</b>	<b>36</b>	Indi				
		<b>37</b>	Sindigi				
		<b>38</b>	Muuddebihal				
		<b>39</b>	Bagewadi				
		<b>40</b>	Talikot				

### Annexure – III

<b>Brief details of budget provision under Child Health Program for Fy: 2010-11</b>					
Code	CHILD HEALTH PROGRAMME	Unit cost	Proposed units	Total (Rs. lakhs)	
A 2.2	Tertiary Neonatal Care at Pvt. /medical college hospitals (@ Rs. 1500/day x 5 days + Rs. 1000 for mother = 8500 x 3000 cases)			225.00	225.00
A.2.3	For implementation of HBNCC in 7 districts (workshop) – SEARCH, Gadchiroli			10.00	10.00
<b>A 2.8</b>	<b>Other Activities / strategies</b>				
A.2.8.1	Infant death audit (@ Rs. 100 / infant death x 45000 infant deaths): (50%)	0.001	22500	192.50	22.50
A.2.8.2	Prevention & Management of Infant blindness in Karnataka				120.00
A 2.8.3	Nutritional Rehabilitation Centres (NRC)	25.00	2		50.00
<b>A.9.1.5</b>	<b>Infrastructure &amp; Human Resource - FBNCC</b>				
	a) Facility Based Newborn Care at 19 district hospitals (manpower for 57 MBBS doctors):	7.5	19	318.25	142.5
	b) Facility Based Newborn Care at 19 district hospitals (12 staff nurses): (@ Rs. 7000/ Staff Nurse x 10 months x 228 Staff nurses)	8.4	19		159.6
	c) Child health counsellor (19 DH x 1Counselor)	0.85	19		16.15
<b>A 12.3.2</b>	<b>Printing formats for Infant Death Audit forms/ reports, early breastfeeding, IMNCI formats etc</b>				
<b>B 19.2</b>	<b>Procurement - Child Health</b>				
B19.2.1	a) District Hospital: Facility Based Newborn Care at 19 district hospitals Sick Newborn Care Unit (SNCU) - DH (@ Rs. 25.00 lakh / DH x 19 DH)	25.00	19	961.07	475.00
	b) Women & Children Hospital & General Hospital: Facility Based Newborn Care, Sick Newborn Care Unit (SNCU) - DH (@ Rs. 16.00 lakh/ WCH&GH x 15)	16.00	15		240.00

	c) Govt. Medical College Hospital (10) for Sick Newborn Care Unit (SNCU) for FBNC (@ Rs. 13.50 lakh x 10 medical colleges)	13.50	10		135.00
	d) FRUs: Stabilisation unit - FRU (@ Rs. 1.00 lakh x 63 taluk hospitals in 14 IMNCI districts, excluding district headquarters)	1.00	73		73.00
	Augmentation of facilities in NICU, PICU, SNCU at Indira Gandhi Institute of Child Health (IGICH), Bangalore	38.07	1		38.07

## CHAPTER 8

### Suvarna Arogya Chaitanya

**126. Introduction:** The School Health Service is the Personal Health Service and is being implemented from many years, from narrower concept of medical examination of children to the present day concept of comprehensive care of Health and well being of children throughout the academic year.

**127. Objectives:** The School Health Programme is being implemented in all the Primary, Higher Primary and High schools in both Rural and Urban areas of the State. All the District Health and F.W Officers are implementing the Programme effectively as per the instructions of this Directorate.

#### The following are the various activities.

1. Medical Examination of the students of 1<sup>st</sup> to 10<sup>th</sup> std of all Government Schools, Aided, unaided and Residential Schools.
2. Immunization of children - DT to 1st Std. Students & 10 years TT to 4<sup>th</sup> Std. Students and 16 years TT to 10th Std. Students.
3. Providing treatment for minor ailments.
4. Students requiring specialist care are referred to nearest hospital regularly and those who requires super speciality services are referred to Yeshaswini Network Hospitals under NRHM Fund.
5. Health Education to teachers as well as students regarding personal hygiene, environmental sanitation, safe drinking water and use of latrines are being taught regularly.
6. Teachers training on School Health are being conducted at Primary Health Centre level.
7. First Aid Kits are supplied to schools of rural areas through Village Health Sanitation Committee under NRHM Fund.

**128.** This is the programme being implemented by two departments i.e., Department of Public Instruction and Department of Health and FW Services.

**129.** Under School Health Programme children studying in 1-10th Std. in Govt. schools, Aided, unaided and Residential Schools, are medically examined & treated. Since 2006-07 under Suvarna Arogya Chaitanya Programme children needing major operation / treatment are identified and treated at major hospitals identified under Yashaswini Scheme. (Heart operation, orthopedic, Eye surgery, etc.) Implant cost, investigations & travel expenses to Students/Parents are also covered under this scheme funded from NRHM.

**130.** During 2008-09, 80,82,192 students from 1<sup>st</sup> Std to 10<sup>th</sup> Std were examined, 12,45,639 treated at PHC/ TH/ Dist Hospital. 1415 Children are operated upto end of March - 09 at a cost of Rs.7.78 Crores.

**131.** During this year i.e., 2009-10 , 76,08,059 students are examined from 1<sup>st</sup> Std to 10<sup>th</sup> Std , and 9,99,360 were found to have different diseases & 7,95,559 are treated at PHC/TH/Dist.Hospital. And 2206 cases were referred to tertiary care Hospitals.

**132.** 1148 cases operated upto 30<sup>th</sup> Nov. 15<sup>th</sup> at a cost of Rs.5,65,17,619 Crores. NRHM funds under VHSC Scheme is used for supply of First aid kits to all Primary and Secondary schools.

**133.** Suvarna Arogya Chaitanya School Health Programme was linked with the Yeshaswini Scheme. Under suvarna Arogya Chaitanya the only criteria to get benefit of the yeshaswini scheme is that the boy or girl must be a school going student. This is certified by the School Head Master and the Medical Officer of the concerned Primary Health Centre in Form-I.

**134.** Suppose, the required treatments/surgeries are not available in the PHC, the concerned MOH, PHC will refer the student to the District Hospital for further treatment/surgery. The available services will be provided at District level. Some students require Super Speciality Surgeries, such students will be referred to the Yeshaswini Network Hospitals alongwith the Health Checkup Card and Annexure-II signed by the concerned District Surgeon. In Yeshaswini Network Hospitals, after following certain procedures at recognized 1600 surgeries will be performed as per the requirement of the concerned students.

**135.** The investigation charges, implant charges, surgery charges and to and fro journey fare to the student and a parent is borne by NRHM Fund released to the Yeshaswini Trust.

For the year 2010-2011 PIP, the following activities are planned under Suvarna Arogya Chaitanya School Health Programme.

**Proposed PIP for the year 2010-11 for Suvarna Aroghya Chaithanya School Health Programme**

<b>Sl.No</b>	<b>Activities</b>	<b>Unit Cost (Rs.in Lakhs)</b>	<b>Total (Rs.in Lakhs)</b>
	<b>SAC School Health Programme</b>		
<b>B.13.1</b>	<b>Surgeries under Yashasvini Network Hospitals</b> 2008-09- Rs.7,19,86,961 (1537 cases) 2009-10 Rs. 10,54,12,765 (2072 cases)		<b>1000.00</b>
<b>B.13.2</b>	<b>Training/Meeting/Workshop at State Level :</b>  RCHO/DHEO/DNO+ State Level Officers Approximately 100 members x 2 Sessions	<b>Rs.0.25</b>	<b>0.50</b>
<b>B.13.3</b>	<b>IEC Activities :</b> Electronic Media (TV) Preparation and Broadcasting of TV Spots Radio Jingles Preparation and Broadcasting of Radio Jingles Print Media a) Advertisement in News Paper b) Printing of Folders/Pamphlets/Posters/Stickers/ Hoardings to each District Head Quarter Approximate Rs.50,000 x 30 Districts x 2 Nos	<b>10.00</b>   <b>5.00</b>  <b>5.00</b>  <b>30.00</b>	<b>50.00</b>
<b>B.13.4</b>	<b>Health Promotion Activities at Schools : Two Districts(Pilot)</b> Innovative Scheme one from North Karnataka and One South Karnataka) <ul style="list-style-type: none"> <li>• Health Mela - Procession with Service activities</li> <li>• Health Clubs in schools</li> <li>• Counselling skill training to teachers</li> <li>• Health and Hygien education at school</li> <li>• Life skill education to teachers/students</li> <li>• Promotion of Parents, Teachers Association</li> </ul> Contingency and Office Maintainance at both state and 2 District		<b>44.00</b>
<b>B.13.5</b>	Transport Facility to State Level Officer (Deputy	<b>0.25X12</b>	<b>3.00</b>

	Director School Health and ARSH) : (Hiring of Vehicle)	<b>months</b>	
<b>B.13.6</b>	<b>Computer Assistant Payment at State Level</b> (Contractual Staff) :	<b>0.10x12</b> <b>months</b>	<b>1.20</b>
<b>B.13.7</b>	Computer with Printer and Laptop :		<b>1.30</b>
<b>B.13.8</b>	<b>Monitoring &amp; Evaluation of School Health &amp; ARSH Programme</b> Honorarium to State Level Officer	-	-
	<b>GRAND TOTAL</b>		<b>1100.00</b>

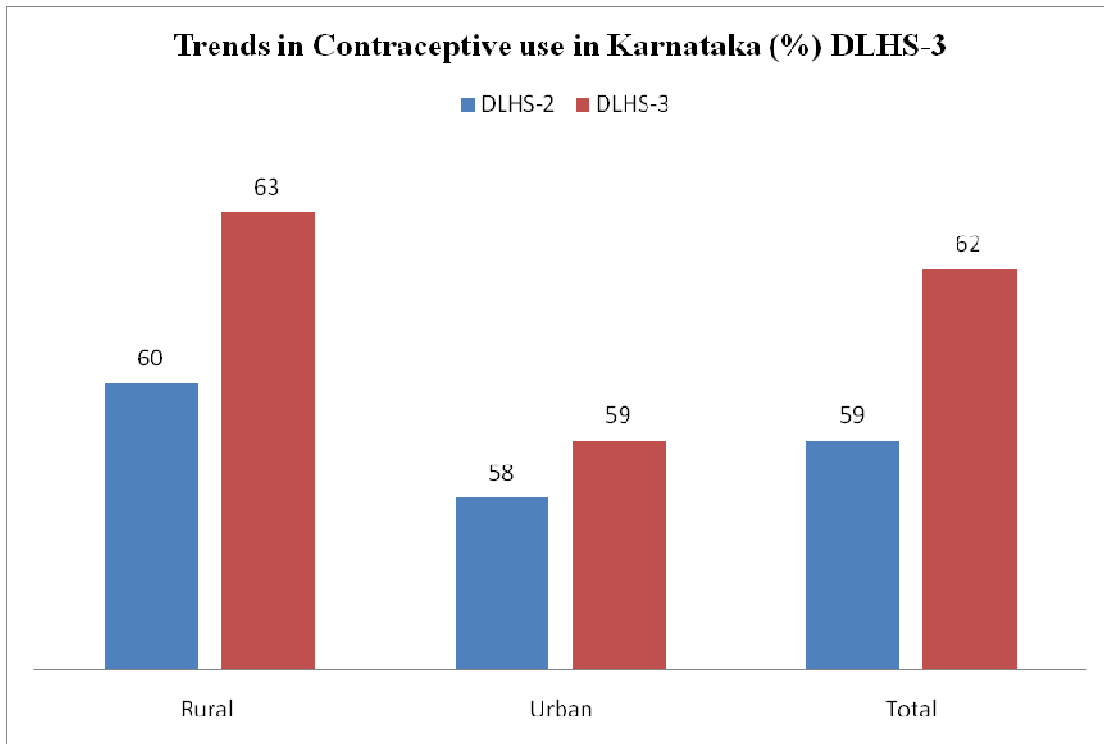
## CHAPTER 9

### Family Welfare Programme

#### 136. Situational Analysis:

DLHS-3 survey of Karnataka has come out with the following findings:

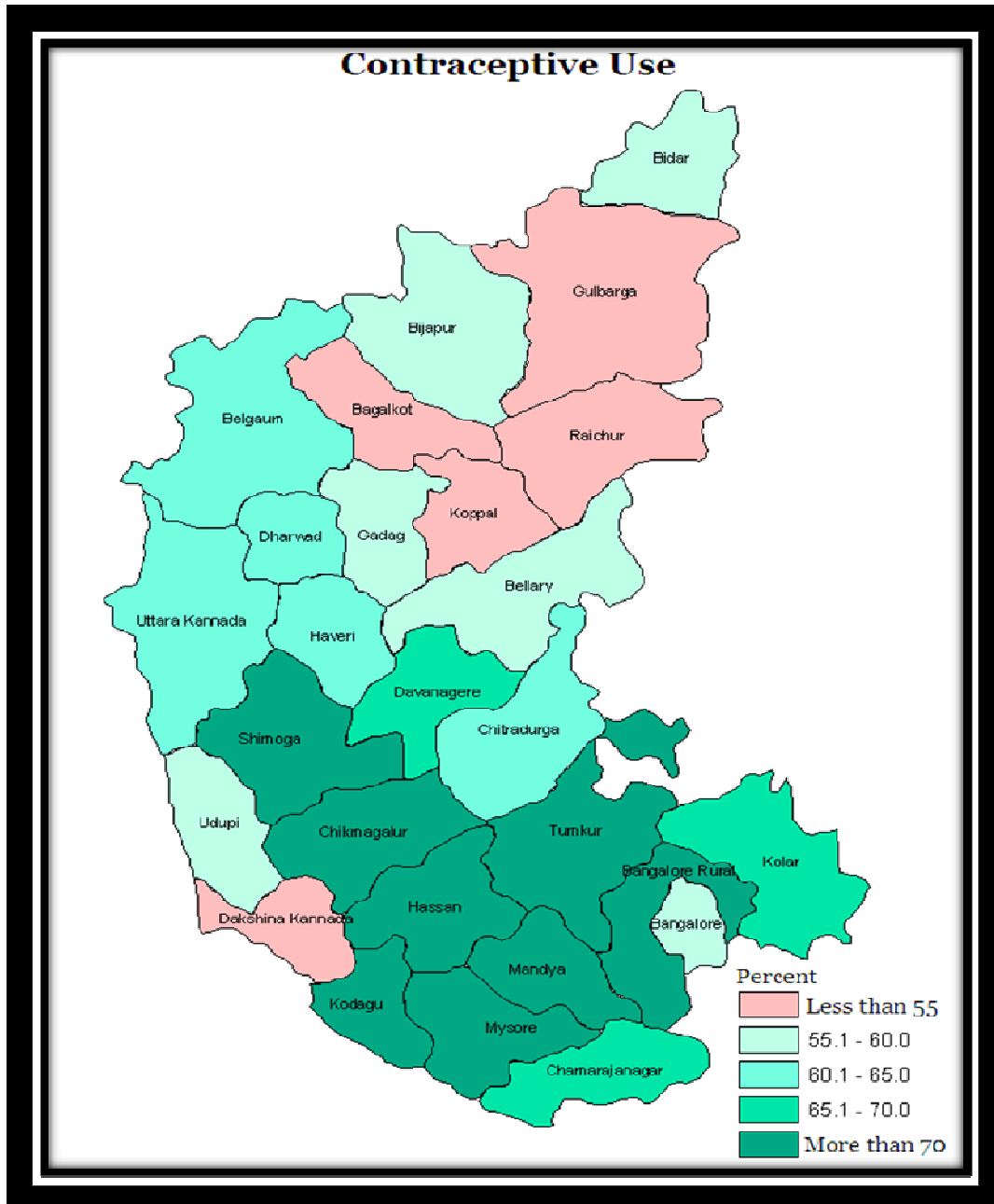
- 10.7% of the total births occur in women in the age group of 15-19 years and 60% of the total births occur in women in the age group of 20-24 years. About 60% of women with two children want no more children.
- Contraceptive Prevalence Rate in Karnataka is about 63 %. Analysis of the different Family Planning methods used by eligible couples show that Female Sterilization as the most popular method and Male Sterilization is the least preferred method and Spacing methods is used by only 1-3% of the couples which has remained unchanged for the last 3-4 years (NFHS-3), which is depicted in the following diagrammatic presentation.



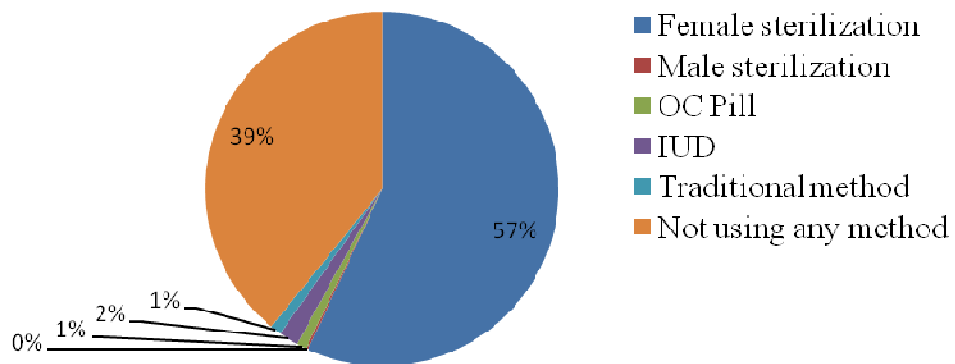
**Table1: showing Unmet Need in Karnataka as per DLHS-3**

<b>District wise Unmet Need for Spacing methods in Karnataka DLHS-3</b>			<b>District wise Unmet Need for Limiting methods in Karnataka DLHS-3</b>		
<b>Districts</b>	<b>%</b>	<b>Rank</b>	<b>Districts</b>	<b>%</b>	<b>Rank</b>
Kodagu	4.3	1	Mandya	3	1
Mandya	4.8	2	Bangalore Rural	4.7	2
Hassan	5	3	Haveri	4.9	3
Bangalore (U)	5.8	4	Bagalkot	4.9	4
Chickmagalore	5.9	5	Hassan	4.9	5
Bangalore Rural	6	6	Belgaum	5.1	6
Mysore	6	7	Shivmoga	5.6	7
Uttar Kannada	6.6	8	Chitradurga	5.7	8
Shivmoga	6.8	9	Bijapur	5.8	9
Tumkur	6.8	10	Bellary	6.1	10
Udupi	6.9	11	Chamarajnagar	6.1	11
Kolar	7	12	Kolar	6.2	12
Chamarajnagar	7.2	13	Dharwad	6.2	13
Chitradurga	8.1	14	Gadag	6.2	14
Haveri	9.7	15	Koppal	6.2	15
Bellary	10.5	16	Chickmagalore	6.5	16
Dharwad	11.2	17	Mysore	6.9	17
Gadag	11.2	18	Tumkur	7.6	18
Bidar	11.2	19	Raichur	8	19
Belgaum	11.4	20	Bidar	8.8	20
Gulbarga	11.6	21	Kodagu	9.5	21
Dakshina Kannada	12.9	22	Bangalore Urban	11.9	22
Bijapur	13.3	23	Udupi	12.3	23
Bagalkot	14.3	24	Gulbarga	12.3	24
Raichur	15.4	25	Uttar Kannada	13.3	25
Koppal	16.4	26	Dakshina Kannada	16.6	26
<b>State</b>	<b>9.1</b>		<b>State</b>	<b>8</b>	

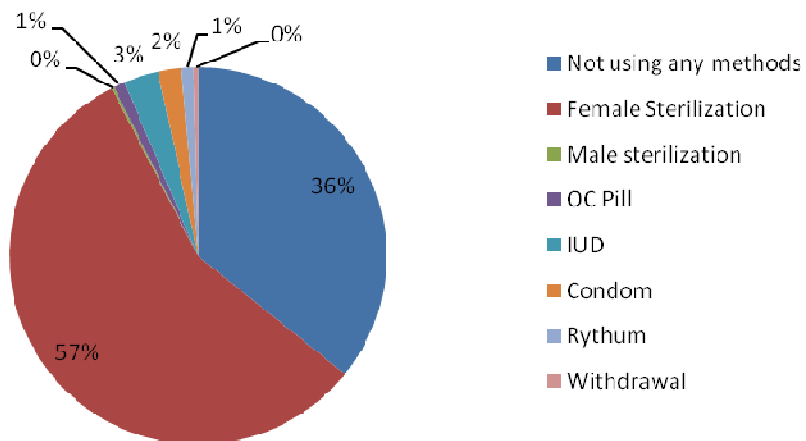
**District wise Contraceptive Prevalence Rate in Karnataka as per DLHS-3**



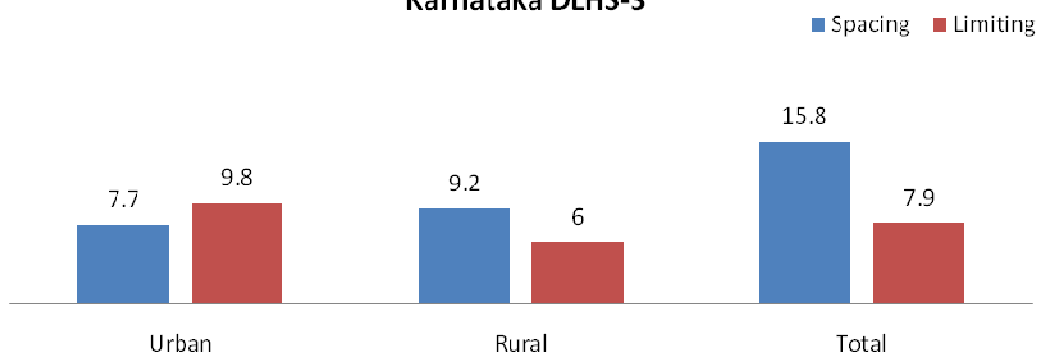
### Users of FP methods DLHS-3 Karnataka



### Contraceptive methods used by women in Karnataka NFHS-3



### Unmet Need for FP (%) Karnataka DLHS-3



**Table 2: STERILIZATION ACHIEVEMENT FROM APRIL 2009 TO DECEMBER 2009 IN KARNATAKA**

Sl No.	District	ANNUAL ELA (TARGET)	Proportionate Target up to end of Dec 09	Female Sterilization Achievement up to Dec 09	NSV up to Dec 09	Total Sterilization up to Dec 09	% of Annual Target	Rank
1	BCC	38069	28552	20409	64	20473	54	20
2	BAN (URBAN)	18891	14168	14008	85	14093	75	1
3	BAN (RURAL)	7525	5644	5542	33	5575	74	2
4	CHITRADURGA	14191	10643	8110	214	8324	59	14
5	DAVANAGERE	16478	12359	10395	8	10403	63	8
6	KOLAR	12348	9261	7554	31	7585	61	10
7	SHIMOGA	15541	11656	7037	26	7063	45	24
8	TUMKUR	24493	18370	10024	15	10039	41	27
9	RAMANAGAR	9083	6812	5439	1	5440	60	13
10	CHIKKABALAPUR	10168	7626	6867	60	6927	68	4
11	BELGAUM	43709	32782	25796	212	26008	60	12
12	BIJAPUR	23884	17913	10246	61	10307	43	26
13	BAGALKOTE	21087	15815	12196	59	12255	58	17
14	DHARWAD	18500	13875	12873	226	13099	71	3
15	GADAG	11630	8723	5279	31	5310	46	23
16	HAVERI	15120	11340	8846	11	8857	59	15
17	U.KANNADA	13316	9987	4926	32	4958	37	28
18	BELLARY	25946	19460	11469	620	12089	47	22
19	BIDAR	15211	11408	9716	86	9802	64	7
20	GULBARGA	34445	25834	19804	21	19825	58	16
21	KOPPAL	14135	10601	6931	58	6989	49	22
22	RAICHUR	16648	12486	11123	15	11138	67	5
23	CHIKMAGALUR	9168	6876	4947	21	4968	54	18
24	D,KANNADA	17674	13256	5159	7	5166	29	29
25	UDIPI	9318	6989	4056	20	4076	44	25
26	HASSAN	14271	10703	7495	144	7639	54	19
27	KODAGU	4701	3526	2264	35	2299	49	21
28	MANDYA	13452	10089	8198	12	8210	61	11
29	MYSORE	25738	19304	16384	130	16514	64	6
30	CHAMARAJNAGAR	7556	5667	4784	4	4788	63	9
31	STATE TOTAL	<b>522296</b>	<b>391722</b>	<b>287877</b>	<b>2342</b>	<b>290219</b>	<b>56</b>	

**Table 3: Showing Spacing Methods achievement from April 09 to December 09 in Karnataka**

<b>District wise Progress of Spacing methods from April 09 to December 09 in Karnataka</b>							
Sl. No.	District	IUD		CC		OP	
		Achievement up to Dec 09	% of Achievement to Annual ELA (Target)	Achievement up to Dec 09	% of Achievement to Annual ELA (Target)	Achievement up to Dec 09	% of Achievement to Annual ELA (Target)
1	BCC	19310	72	11260	26	5484	19
2	BAN (URBAN)	11543	86	21870	104	9567	66
3	BAN (RURAL)	3969	84	5264	75	2652	57
4	CHITRADURGA	5952	69	9530	75	7108	85
5	DAVANAGERE	8274	82	12680	85	9879	100
6	KOLAR	6113	79	8081	70	3400	44
7	SHIMOGA	5882	64	6136	46	5466	62
8	TUMKUR	10931	75	11893	57	4867	35
9	RAMANAGAR	4605	81	5067	60	2464	44
10	CHIKKABALAPUR	5190	81	6767	71	3946	62
11	BELGAUM	17560	71	31926	91	18905	83
12	BIJAPUR	7091	62	14781	103	8360	97
13	BAGALKOTE	7197	70	18886	142	7471	91
14	DHARWAD	7348	76	13153	101	5919	72
15	GADAG	3575	62	5127	68	3834	82
16	HAVERI	7898	94	14135	121	6445	86
17	U.KANNADA	3418	45	10126	93	3997	57
18	BELLARY	4986	39	5935	35	10951	105
19	BIDAR	6690	75	11725	91	7632	91
20	GULBARGA	10124	53	17154	64	7549	44
21	KOPPAL	2687	36	4540	44	2349	36
22	RAICHUR	7390	74	5880	40	5357	55
23	CHIKMAGALUR	3810	62	5988	63	1719	27
24	D,KANNADA	6442	60	13768	86	4806	46
25	UDIPI	3565	60	7709	87	2422	41
26	HASSAN	5943	65	11883	85	3099	33
27	KODAGU	2127	71	2801	62	1072	35
28	MANDYA	5418	59	5638	40	5270	55
29	MYSORE	10245	68	13725	63	8032	56
30	CHAMARAJNAGAR	2904	57	4926	63	2482	47
31	STATE TOTAL	<b>208187</b>	<b>68</b>	<b>318353</b>	<b>71</b>	<b>172505</b>	<b>59</b>

**137. Goals:** Bring down the TFR to 1.9 during the year 2010-2011

**138. Objectives:**

1. To make Family Planning methods accessible and available to eligible couples as near as possible to their homes.
2. To ensure Quality Family Planning services.
3. To reduce the high Unmet Need for both spacing and limiting methods
4. To provide Family planning services to Urban, Tribal and left out pockets through PPP.

**139. Strategies:**

- To provide Quality Sterilization Services by arranging Fixed Day Static Approach services nearest to their homes by trained manpower posted at the facilities.
- To address the Unmet Need for FP services, both spacing and terminal methods are made available in the nearest Health Facility to the beneficiaries.
- To assist the beneficiaries to select the methods of their choices, more emphasis is given for counseling by utilizing the services of the ICTC counselors and BHEs and other Health Workers.
- IEC activities to be strengthened by wall paintings, Hoardings, Wall posters, hand bills, TV spots, Radio Jingles, and Radio and TV sponsored programmes.
- To provide Quality services OTs will be repaired and beneficiary friendly amenities are provided client satisfaction and to reduce complications, failures and deaths.
- Quality Assurance Committees to meet regularly at least once in three months at district and state level to do facilities audit, audit complications, failures and deaths due to sterilizations.
- To increase the manpower Doctors, Staff Nurses and OT attendees will be trained in Minilap, Laparoscopic and No Scalpel Vasectomy surgeries.
- Ensuring male participation in Family Planning and emphasis on NSV
- To increase the NSV service providing surgeons in the state, District level trainers have been identified to provide training to the deputed doctors at NSV Camp sites.
- To make adequate surgical equipments available at the operating sites, districts are delegated the powers to procure Laparoscopes, Minilap sets, and NSV sets and budget would be released.
- Establishing PPP with Private Nursing Homes and Hospitals

**140.** Overall Contraceptive Prevalence Rate in Karnataka as per DLHS-3 is 63%, and the most widely accepted FP method is female sterilization which is about 57% and the unmet need for spacing in Karnataka as per DLHS-3 is 8%. To meet this demand of sterilization services, sterilization camps are arranged as near as possible to their homes.

**141.** General sterilization camps are arranged in PHCs, CHCs, Taluk Hospitals, District Hospitals, Medical College Hospitals, and in Private Nursing Homes and NGO Hospitals based on the availability of Surgeons, OTs and Laparoscopes. General Sterilization camps are arranged as shown in the tables below:

**Table 4: Details of General Female Sterilization Camps**

<b>Details of General Female Sterilization Camps</b>				
<b>Health Institutions</b>	<b>No of Camps/Month Or No of Camps/Quarter</b>	<b>Months</b>	<b>No of Institutions</b>	<b>Total no Camps during 2010-2011</b>
<b>District Hospitals</b>	3/month	12	30	<b>1080</b>
<b>Taluk Hospitals</b>	3/month	12	176	<b>6336</b>
<b>CHCs</b>	5/Quarter	4Quarters	189	<b>3780</b>
<b>PHCs</b>	1/month	8	300	<b>2400</b>
<b>Total</b>				<b>13,596</b>

**142.** To ensure beneficiaries regular fixed camps nearest to their homes Fixed Day Static approach Female sterilization services are arranged as shown in the table below:

**Table 5: Details of FDS Female Sterilization Camps**

<b>Details of FDS Female Sterilization Camps</b>				
<b>Health Institutions</b>	<b>No of Camps</b>	<b>Months/Quarter</b>	<b>No of Institutions</b>	<b>Total no Camps during 2010-2011</b>
<b>District Hospitals</b>	1/ Month	12 Months	30	<b>360</b>
<b>Taluk Hospitals</b>	1/ Quarter	4 Quarters	146	<b>584</b>
<b>CHCs</b>	1/ Quarter	4 Quarters	189	<b>756</b>
<b>PHCs</b>	2 camps / year	5 PHCs	30 districts	<b>300</b>
<b>Total</b>				<b>2000</b>

**Table 6: Details of Total Female Sterilization Camps for 2010-2011**

<b>Details of Total Female Sterilization camps planned for 2010-2011</b>			
<b>Health Institutions</b>	<b>General camps</b>	<b>FDS camps</b>	<b>Total camps</b>
<b>District Hospitals</b>	<b>1080</b>	<b>180</b>	<b>1440</b>
<b>Taluk Hospitals</b>	<b>6336</b>	<b>292</b>	<b>7040</b>
<b>CHCs</b>	<b>3780</b>	<b>378</b>	<b>4536</b>
<b>PHCs</b>	<b>2400</b>	<b>150</b>	<b>3600</b>
<b>Total</b>	<b>13,596</b>	<b>1000</b>	<b>16616</b>

**143.** To increase male participation in Family Planning methods and to popularize NSV, Fixed Day Static approach NSV services are planned for 2010-2011 as shown in the table below:

**Table 7: Details of FDS Male Sterilization Camps planned for 2010-2011**

<b>Details of FDS Male Sterilization Camps planned for 2010-2011</b>				
<b>Health Institutions</b>	<b>No of camps</b>	<b>Months/Quarters</b>	<b>No of Institutions</b>	<b>Total no Camps during 2010-2011</b>
<b>District Hospitals</b>	One camp every 2 months	6 Months	30	<b>180</b>
<b>Taluk Hospitals</b>	Twice a year	2/year	146	<b>292</b>
<b>CHCs</b>	Twice a year	2/year	189	<b>378</b>
<b>PHCs</b>	1 camp / year	5 PHCs	30 districts	<b>150</b>
<b>Total</b>				<b>1000</b>

**Total cost of FDS camps**

<b>Female FDS</b>	<b>2000 x 0.15 lakhs</b>	<b>300.00 lakhs</b>
<b>NSV FDS</b>	<b>1000 x 0.35 lakhs</b>	<b>350.00 lakhs</b>

#### 144. Public Private Partnership in Family Planning programme:

Private Nursing Homes, Charitable Hospitals, NGO Hospitals are also providing sterilization services in the Urban and Semi Urban areas, particularly in District places. In some of the coastal districts like Dakshina Kannada, Udupi and Uttar Kannada beneficiaries usually prefer private hospitals for MCH and Family Planning services. These districts are having high unmet need for both spacing and limiting methods and the target achieved in these districts is very poor when compared to other districts. Taking all these into consideration, Janasankya Stirata Kosh programme for population stabilization –Santushti Programme will be implemented after empanelling surgeons, accreditation of private hospitals and entering into MOU as per JSK-Santushti guidelines. Under Santushti programme in each district minimum of two eligible private hospitals will be identified and minimum of 150000 sterilization surgeries are planned and the budget will be obtained from JSK fund.

Budget planned for Family Planning Sterilization services is as per the table given below:

**Table 8: Budget for FP Sterilization Services during 2010-2011**

Sl No	Component	Unit Price (in lakhs Rs)	No of Units	Budget (in lakh Rs)
1	NSV	0.015	10000	150
2	<b>Female sterilization</b>			
	APL	0.0065	140906	916
	BPL	0.01	355275	3552.75
3	<b>FDS NSV Camps</b>	0.35	2420	847
4	<b>FDS Female Sterilization</b>	0.15	3020	453
	<b>Total</b>			<b>5918.75</b>

#### Quality Assurance in FW services:

145. To ensure quality FP services guidelines issued by GOI as per Standards of Male and Female sterilization services and guidelines of Quality Assurance will be strictly adhered. 5000 copies of manuals of Quality Assurance and Standards of Male and Female Sterilization will be printed and supplied to all service providers and Medical Officers to adhere to quality norms.

Quality Assurance Committee meetings will be held under the chairmanship of Deputy Commissioners at district level every quarter and as and when need arises. In QAC

meetings issues regarding quality of FP services will be reviewed and remedial actions will be taken, cases of death, failures and complications following sterilization operation will be audited and claims to the Insurance Company will be submitted through QAC. 5% of the facilities providing sterilization services will be audited by the QAC by spot inspection.

**146.** To provide quality services and to ensure sufficient trained manpower, required surgeons and other staff will be trained at FDS (See: training write up)

To ensure availability of Laparoscopes at each Taluk Hospital 50 Laparoscopes have been procured in 2009-10 another 50 Laparoscopes procurement has been planned in 2010-11. To ensure quality at camp sites equipments and supplies have been planned and budgeted as shown in the table below:

Sl no	Name of the item	Unit price (in lakh Rs)	No of Units	Budget (in lakh Rs)
1	Laparoscopes	5.25	50	262.50
2	NSV sets	0.0094	2000	18.75
3	Printing of Standards of Male & Female Sterilization Manuals and Quality Assurance Manuals	0.001	10000 (5000 copies of Standards of sterilization and QAC manuals)	10.00
4	Repair of laparoscopes and other equipments		30 Districts	50.00
	<b>Total</b>			<b>341.80</b>

**147. Spacing Methods:** As per DLHS-3 less than 4% of the Eligible Couples are using spacing methods and Unmet Need for Karnataka is 9.1% and in some of the poorly performing Districts like Koppal, Raichur, Bagalkot, Bijapur, Dakshina Kannada and Gulbarga it is between 16.4% and 11.4%. During 2010-2011 emphasis will be on spacing methods.

**148.** IUCD 380 A training is planned for Doctors, Staff nurses, LHVs, ANMs and IUCDs will be made available in all the 5143 Sub Centers with Government buildings, PHCs, CHCs, Taluk Hospitals, District Hospitals, and Medical College Hospitals. In urban and semi urban areas Nursing Homes and Private Hospitals with required facilities and qualified doctors, contraceptives will be supplied free of cost and asked to supply to the beneficiaries for nominal service charges and also to leading Gynecologists clinics contraceptives will be provided and will be requested to issue to their patients at nominal service charges. Regular reports will be collected and these beneficiaries will be followed by Urban Health Center Health Workers.

ASHA workers have been trained in contraceptive promotion and their services will be utilized to follow up women who have been inserted IUDs and they will make first visit after 48 hours, second visit after 7 days, third visit after one month and fourth visit after three months and they will get Rs 50 as follow up for IUD retention. Budget for IUD services is as given below:

<b>Sl no</b>	<b>Components</b>	<b>Unit price (in lakh Rs)</b>	<b>No of units</b>	<b>Budget (in lakh RS)</b>
1	IUD Contingency	0.0002	308250	61.65
2	IUD follow remuneration for ASHAs	0.0005	200000	100.00
3	<b>Total</b>			<b>161.65</b>

## CHAPTER -10

### ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH (ARSH)

#### Introduction:-

**149.** Adolescent (10-19 years) constitute about 22% of India Population. Nation is investing in their education, health and development adequately. In order to ensure that they grow healthy, they require information and skills, health services and counseling as well as safe and supportive environment.

#### **150. Main objective :-**

The main objective of this programme is to bring down IMR/MMR/TFR.

#### **151. Sub objectives:-**

1. Age at marriage – control early marriages.
2. To improve Nutritional States in adolescents especially in girls.
3. To provide Health facilities and services to adolescents through “SNEHA CLINIC” .
4. To provide Health Education- with in the school & out side the school adolescents & general public.

**152.** As far as age at marriage is concerned, it was found that a large number of girls marry in India, before the age of 18 which is risky in terms of earlier sexual activity, pregnancy, STIs etc. The various issues related to maternal health of Adolescent were also analyzed and found that, overall access and Utilization of Services at antenatal care (ANC), MTP, Spacing, STI/RTI, HIV/AIDS etc, adolescent group required attention.

5. Hence, GOI launched ARSH programme through out the nation. Karnataka State also launched this programme from last year. 12 districts are selected for implementing the ARSH programme out of 29 districts in the state.
6. In the first phase, Medical Officers Training has been completed in these 12 districts and para medical staff like Jr. Health Asst(F) and Sr. Health Asst(F) training is near completion. As far as awareness creating programme in the field level sensitization programme for self help group members, school Teachers are being conducting. Awareness creating programme for community at large through All India Radio, every week on Saturday morning at 7.15 a.m. 15 minutes radio lessons (in drama form) are broadcasted throughout Karnataka. And also sensitization programme for Anganwadi workers, ASHA, ICTC counselors are planed.
7. Services are provided regularly in the OPD at all PHC/CHC/TH . In addition on every thusday between 3 to 5 p.m. “ Special Adolescent Clinic” in the name of ‘SNEHA CLINIC’ is conducted in all PHCs, Taluk and Dist Hospitals, Counselling Services also rendering at the same time.

8. Activities carried out in selected 12 districts during 2009-10.
9. Training of Medical officers and other paramedical personnel in 12 districts.
10. Sensitization of self Help group members in each PHC 5 groups.
11. Sensitization of school teachers at PHC level.
12. From 19-12-09 through All India Radio in the name of “ VASANTHA AGAMANA” a weekly programme radio lesson lunched, totally 26 episodes is broadcasting.
13. And Radio jingles will broadcast from 1st Feb 2010 to March 2010. In different channels of AIR. In this connection agreement is finalized. Other educational activities like T.V. spots, and print media work is under progress.
14. It is proposed to take-up ARSH Programme in the entire state during 2010-11.
15. The proposals for 2010-11 PIP is as follows:-
16. Training:-
17. Training of Medical officers and other paramedical staff has been already planned under ARSH programme and approximate cost will be Rs. 184 lakhs. Details may be seen in training components prepared by the SIHFW.
18. Drugs:-
19. De worming and iron tablets will be supplied by education department directly to the primary and higher schools every year for Government and Aided schools.

**Budget**

Sl.No	Activities	Total (Rs.in Lakhs)
A.4.1	Sensitization of Self Help Group Members 5 Programmes X total No.of PHC X Rs.200/-	21.93
A.4.2	Sensitization of School Teachers at PHC Level. No.of PHCs X Rs.500/-	10.96
A.4.3	Sensitization of PRI Members No.of PHCs X Rs.500/-	10.96
A.4.4	Essay Competition for High School Students No.of Taluks X Rs.1500/-	2.64
A.4.5	Debate Competition for PUC Students No.of Taluks X Rs.1500/-	2.64
A.4.6	Yuvajana Mela No.of Taluks X Rs.2000/-	3.52
A.4.7	IEC Materials ( Printing at Taluk.Level) - Tq. Level = 176x2000/-=Rs. 3.52	3.52
A.4.8	IEC Materials ( Printing at Dist.Level) Dist. Level = 30x5000/-=Rs.1.50	1.50
A.4.9	Satelite Programme	20.00
A.4.10	AIR Programme	10.00
A.4.11	TV Programmes	10.00
A.4.12	Pilot District Special Activity	30.00
A.4.13	Print Media/Sensitisation of District level officers at state level	7.33
	<b>Total</b>	<b>135.00</b>

## CHAPTER - 11

### URBAN RCH

**153.** With increasing urbanization, growth of slums and low income population in the cities, the provision of assured and credible primary health services of acceptable quality has emerged as a priority thrust area for both the central and state Governments. The need has arisen to create a well-organized health service delivery structure in urban areas especially for poor people living in slums. The emerging importance of the problem can be gauged from the fact that the total population of Karnataka state is 5,28,50,562 and the urban population is 1,79,61,529.



#### **154. Goal and objective of the program:**

To improve the health status of the urban poor community by the provision of quality integrated Primary Health Care services.

**155. Objective:** The main objective of the program is to provide an integrated and sustainable system for primary health care services delivery in the urban areas of the State, with the focus on the urban poor living in slums and other vulnerable health groups.

#### **156. To attain this, the specific objectives will be:**

Establishing new facilities in 44 identified urban slums areas, which are not covered by urban health centers.

Establish referrals with tertiary care centers, i.e. District hospitals, Medical colleges etc for institutional deliveries, emergency obstetric care and terminal method of family planning.

Appoint link workers who will act as link between community and health facility.

### **157. Program description:**

**Coverage:** The program would be implemented in a phased manner in 44 selected towns of Karnataka states. The proposed urban health program will focus on cities having a population between one to ten lakh/ It is proposed to cover these cities in the phased manner as per the following:

Phase	I	II	III	IV	V	Total
Year	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
No. of Centres	4	6	8	13	6	7

### **158. Strategies:**

State level steering committee for urban health activities has been constituted. Mapping of 44 urban slums has already been completed; basic demographic and health indicators have been collected.

Each of proposed urban health centers will cover a population of 50,000.

Lady medical officers/Male medical officer will be appointed on contractual basis for all the selected urban centers. She will be responsible for providing all OPD services and also she will conduct at least 4 outreach visits in her geographic area.

Identification of tertiary referral centers will be done by Lady medical officer of UHC in coordination with the District health officer and will establish formal linkages for service delivery.

Para-Medical Staff i.e, JHAF, SHAF etc and other staff will be appointed on contractual basis. Each JHAF/ANM will cover 15,000 populations for providing outreach services. She has to prepare a micro-plan showcasing the area and days on which outreach services will be provided.

To develop and maintain a link between the health facility and the community, the program envisages the engagement of female link workers for every 5000 population who are in the age group of 23-35 and are able to spare three to four

hours a day, and are acceptable to the community and preferably to be engaged through local NGOs.

**159. Training:** The training programs will be conducted for newly appointed staff of urban health centers.

**160. Present status:** Out of 44 identified cities to start Urban health centers under NRHM, so far 37 centers have been sanctioned during the year 2006-07, 2007-08 2008-09 and 2009-10, It is proposed to start 7 centers during 2010-11.

**161. Budget requirements:**

Budget requirement for appointing Staff for one Urban Center and their remuneration is as follows:

Name of the Post	No. of Posts	Remuneration per Month) in Rupees	Cost per year (in Rs.)
Medical Officer (LMO)	1	17000	204000
LHV / PHN	1	8000	96000
ANM	3	21000	252000
Staff Nurse	1	7000	84000
Lab Technician	1	6500	78000
Clerk	1	6000	72000
Security Guard	1	5000	60000
Link workers	10	10000	120000
		<b>Total</b>	<b>9,66,000.00</b>

1	Annual Maintenance of equipments, Furniture etc for Health Centre (Recurring)	10000.00
2	Electrical, Water, Building charges etc. (Recurring)	24000.00
3	Building maintenance (repair & painting) (Recurring)	15000.00
4	Drugs (Recurring)	28000.00
5	IEC Materials (Recurring)	10000.00
6	Hiring of Vehicles (Recurring)	10000.00

7	Rent for the Building	100000.00
8	Lab consumables	24000.00
	<b>Total</b>	<b>221000.00</b>

(in Rs.)

Annual maintenance	2.21.00
Salary component	9.66.00
Total budget required per center	11.87.00
<b>Budget required for 37 Centres</b>	<b>439.19</b>
<b>Budget required for 7 centre for 6 months</b>	<b>41.54</b>
<b>Total budget required</b>	<b>480.73</b>

i.e.480.73 lakhs.

**Note:** Untied fund of Rs. 50,000.00 per center has been approved in PIP 20010-11 as separate line item.

## CHAPTER - 12

### TRIBAL RCH

#### Introduction

**162.**Karnataka State has a strong commitment to improve the health status of its population, particularly the poor and vulnerable groups including women, children and those belonging to tribal, nomadic and other vulnerable (T&V) groups. Karnataka has 34,63,986 Scheduled Tribes and 85,63,930 of Scheduled Castes population. This represents 6.55% and 16.20 % of the total population of Karnataka respectively (as per 2001 census). Of this total of SC/ST population 20% are tribals and the other vulnerable groups. Knowing very well ST & SCs particularly the tribals have a high disease burden particularly in mothers and children, the RCH II program needs to address this group specifically. This is compounded with illiteracy, poverty, malnutrition, poor sanitation and inadequate access to safe drinking water, utilization of health services by Tribal & Vulnerable is low due to the difficult geographical conditions and the social constraints in which they live. Their settlements tend to be small and isolated and difficult to reach with facilities and services. Even when they live in larger villages they may be separated in hamlets and pockets.

The health related goals are:

- a. Reduce Child Mortality
- b. Improve Maternal Health
- c. Combat HIV/AIDS, Malaria, TB and other specific diseases to tribal's like sickle cell anemia

#### Situation Analysis

**163.**Even though Karnataka remains a high performer in health status when compared to many other states in India with better health indicators, there is scope for improvement. Disaggregated data indicate substantial disparities in various indicators across 29 districts in the state with much worse indicators among the tribal and vulnerable groups. The maternal mortality as well as infant mortality is stated to be specifically high as reported in the State Government (CNA Form 9)

and as reported for various morbidity conditions in mothers and children in DLHS- RHS. NFHS 3 data which is the most recent RCH data also confirms the same. Hence the need to address RCH issues in this vulnerable and tribal group in a focused manner.

#### **164. Strategies to be adopted:**

- ❖ Improving the accessibility
- ❖ Infrastructure development
- ❖ Incentives to health functionaries- Human resources
- ❖ Training
- ❖ JSY
- ❖ IEC
- ❖ Equipment , drugs and supplies

#### **Community Participation:**

**165.**Karnataka has been home to many innovations. One of the objectives of the project is to reduce MMR. And this rate is unacceptably high amongst the women belonging to poorer communities. In order to create awareness on safe delivery practices, PHCs are organizing ‘Samooha Seemantham’ or Community Celebration of pregnancy which has proved to be a good strategy for getting the community actively involved in spreading awareness about safe delivery, post-natal care etc. . On this occasion, pregnant women are honored with a Kum-Kum Tika (Vermillion on their forehead) and are given some incentive like blouse pieces and bangles. This is being conducted at the PHC level and has shown tremendous response in all the districts. The budget is met out of the community contribution & sponsorship.

#### **Activities:**

##### **Tribal area allowance**

**166.**The staff in the tribal areas do not stay in these areas due to lack of accommodation for the staff and poor educational facilities for their children. To

improve the availability of the services and to run 24x7 PHCs it is envisaged to encourage the staff to stay in the tribal areas by providing Tribal area allowance in the districts which have a significant tribal population. As approved in the PIP of NRHM of Karnataka for Fy:2009-10, it is proposed to continue Tribal area allowance for 52 PHC's in the districts of Mysore (7 PHC's), Kodagu (30 PHC's) & Chamarajanagar (15 PHC's). It is proposed to provide an additional allowance of Rs.2000 to doctors, Rs.1000 to staff nurses and Rs.750 ANMs in these tribal areas and to continue this allowance to the staff at 52 PHCs. The Budget requirement under this component during Fy: 2010-11 will be approximately. Rs. 48.36 lakhs.

**Tribal Area ANM's Salary working at PHC's**

**167.**The salary component of Rs. 8.00 Lakhs for 20 tribal ANM's working in PHC's which are out sourced under PPP is to be met out of RCH funds. These ANM's are working in tribal areas and are continued from RCH-I

**Annexure**

**Budget: 56.36 lakhs**

**CHAPTER-13**  
**HMIS AND M&E**  
**DEMOGRAPHY AND EVALUATION CELL**

**168. PRINTING OF REGISTERS**

**OBJECTIVE:**

The ANM's at the field level are loaded with lot of work both in the field as well as noting down the services provided in the register. At present they are maintaining around 30 registers of various kinds. By streamlining, we may downsize the No of registers maintained by the ANM's and also Information pertaining to single ANC case will be available in the single register.

**SCOPE:**

Authenticated information may be obtained from the grass root level, since only one register will be maintained. Easy to cross check whenever necessary, and comprehensive report may be prepared every month based on the information.

**DETAILS:**

It is planned to downsize the number of registers maintained by field staff at the SUB\_Centre level. At present around 30 registers are maintained by ANM at the field level. Discussions were held with programme officers, field level staff and Doctors of PHC's to know about the existing registers and its usefulness. These registers are to be printed and supplied to all the subcentres for maintaining the records properly, and also to forward the data to D & E cell in the Directorate.

**ESTIMATE**

There are around 8000 and odd subcentres, need about 10,000 registers for the year 2009-2010. Each ANC case will have 80 columns ie., 5 pages, assuming 25 ANC,s in a month and 5 cases can be entered in 5 pages we require around 30 pages in a month, and for 1 year it works out to be360 pages, and for external cases we may require approximately around 200 pages, and Each register will be printed using A3 size paper.

According to the above assumption we require 10,000 registers of A3 size having 600 pages each. Assuming each register to cost Rs 400, total cost works out to be **40 lakhs**.

### **169.PRINTING OF CNAA FORMS**

#### **OBJECTIVE:**

The Community Needs Assessment Approach Survey, for fixing targets for the following year, is one of the flagship survey of Health and Family Welfare Department. The CNAA Survey gives exact figure about the family welfare programs to be planned and implemented in the geographical area. The CNAA Survey will be conducted as per the guidelines of the Ministry of Health & Family Welfare Department of Government of India, and the same formats as per the directions of GOI will be used for collecting and compiling the data at the filed level.

#### **SCOPE:**

Authenticated information may be obtained from the grass root level pertaining to Maternal and Child health. The guidelines will be the same throughout the State and the same formats will be used across the state for collecting the data. The comprehensive data collected will be utilized to plan and implement the family welfare programmes effectively.

#### **DETAILS:**

The GOI has designed different formats for different Health institutions, viz subcentre, PHC, CHC, etc., The Survey will be conducted from the sub centre level. Household formats will be used to collect various data from individual households. At the end of the survey the district will come out with a comprehensive District Plan and based on this plan the annual targets for various family welfare programmes will be fixed.

#### **ESTIMATE:**

There are around 8000 Plus subcentres, and need about 10,000 subcentre formats, assuming 5 persons per housed hold, we will arrive at 1000 houses in a sub centre, which require 50 formats for one sub centre (20 household data in one format). There are separate formats for PHC, CHC, Taluka and District level, all together it works out to be 8,50,000 formats consisting of 4 pages (average). Assuming Rs. 3/- per format for printing, total cost works out to be around **25 lakhs**.

## **170.PRINTING OF HMIS FORMAS**

### **OBJECTIVE:**

Government of India has introduced the new web enabled data transfer system throughout the country to have uniformity of data flow from all the states. Eventhough the data transfer is through web portal, hard copies are to be maintained in the respective institutions for future reference, and also for data capturing from the field level formats designed by GOI has to be printed and supplied to all the health institutions.

### **SCOPE:**

Collecting data in a standard format supplied by GOI enables us to have a uniform reporting system, and also helps us in co-ordinating in a better way with the Central Government.

### **DETAILS:**

Implementation of WEB-ENABLED reporting system, as per the requirement of Govt Of India, the data has to be captured from Sub Centre level and upwards in the new format supplied by Govt Of India. The new formats have to be printed and Supplied to all the Institutions for capturing the data in the new format.

### **ESTIMATE:**

Total no of Health Institutions of all levels right from SubCentre level works out to be 10675, say around 11,000, and each institute require 25 formats for 1 year and assuming each format is having around 5 sheets (10 pages), and cost of printing each format to be around Rs 10/= per format. The total cost works out to be Rs 27,50,000/= Say **30 lakhs**

## **171.TRAINING PROGRAMME:**

### **OBJECTIVE:**

The CNAAs Survey which is conducted once in a year, needs comprehensive training for the district and field staff. The Assistant Statistical Officers in the districts will be trained in CNAAs survey and also Divisional and District level training programmes will be

organized for PHC staff. All the field level staff are not computer literate, further the web based data transfer system itself is a new concept, which has to be understood properly, unless and until we train the lower level staff, the very purpose of web portal will be defeated, as such training programme to educate the field level staff is a must.

**SCOPE:**

Systematic CNA Survey may be ensured by training the lower level staff, further training the lower level staff we will have uniform flow of data from all the lower health institutions, which will help in accurate consolidation and preparing required reports, further it helps in faster flow of data and helps in analysing the data.

**AIM:**

The aim of this training is to guide to how to conduct the house to house survey to assess the factual number of Eligible Couples who need to be targeted for FWP & the no of children for UIP & pregnant women for T.T. Injection.

**DETAILS:**

The WEB-ENABLED reporting system is a new computerized reporting system, wherein the data flows from the lower level to the State through WEB PORTAL. The lower level staff should be oriented towards the new system and exclusive training has to be imparted. Regular training programmes at the state level, Division level, and at the District level has to be organized.

**172.ESTIMATE CNA SURVEY TRAINING:**

It is assumed that 2 training programmes are arranged in a month from April 2010 at State Divisional level District & Sub-District (District level training also will be organized at district level for which ASO will be the resource persons) onwards for various field level staff and estimating approximately around 50 trainees in each training programme and each programme on an average for 2 days the total cost for each training works out to be Rs 20,000 + Sundry expenses (100 people at Rs 200 per day +Rs 15,000 for logistic support). Total cost works out to be 8,40,000 say **10 lakhs**. Training of about 8143 ANM's are the field workers at Sub Centre (at the rate of Rs. 500/- per participants including training material, sundry expenses and logistics) Rs. 40.00 lakhs.

### **173.EVALUATION STUDY:**

#### **OBJECTIVE:**

Evaluation of ongoing and implemented scheme in any department is a must, for effective planning of other schemes in the department. It helps in identifying the loop holes and problems faced while implementing the programmes, so that best strategy can be worked out to implement the scheme in the right direction.

#### **SCOPE:**

Evaluation studies will have a cross-check and cross verification of various developmental schemes implemented in the department. The lower level staff will work with caution and take extra care while implementing the programmes.

#### **DETAILS:**

The Health department is implementing several beneficiary oriented and development oriented schemes, for the health care of the people. It is mandatory to know how these schemes are reaching the people, and how successful the schemes are for the welfare of the people, further the assessment has to be done based on the feed back from the people. Evaluation studies on some of the Important schemes may be taken up for Evaluation both Inhouse and through External agency.

#### **ESTIMATE:**

Two evaluation studies on important schemes of the department may be considered to be done by external agency, for which an amount of Rs 10 lakhs may be earmarked and further sample check and sample studies can be taken up by the inhouse personnel of demography cell, for which an amount of Rs 20 lakhs may be earmarked, another Rs. 20 lakhs have been proposed for publication of reports. Total Rs. 40.00 lakhs have been proposed for evaluation studies.

### **174.INFRASTRUCTURE SUPPORT:**

#### **OBJECTIVE:**

To have the latest statistical packages and latest computers and printers for the demography wing will help in analysing the data in a better way.

#### **SCOPE:**

Adopting the latest technology available in the market, the demography cell personnel will be equipped and armed with latest technology for providing accurate reports, and also helps in generating the reports on time without delay.

**DETAILS:**

The infrastructure has to be updated keeping in mind the latest developments on the field, Since the D & E cell will be collecting the WEB based reports in near future latest computers and printers has to be procured for the section, further since the D & E cell is planning to take up sample check on various schemes of the department additional Vehicular support is required for the section.

**ESTIMATE**

The total estimated cost of Rs 10 Lakhs may be earmarked for purchasing computers, software and printers. Also 5 lakhs may be earmarked for vehicular support for the section which may be outsourced, which will help the D & E cell to take up the sample check survey effectively.

## Budget

### A. 10.3 MONITORING AND EVALUATION /HMIS

SL NO	PARTICULARS	LINE ITEM (2009-2010 PIP)	UNIT	UNIT COST (RS)	Total requirement	ESTIMATED COST (Rounded of)
	PRINTING OF ANM REGISTERS FOR SUB CENTRE	A 10.3.1	Nos	500	8000	40 LAKHS
1	PRINTING OF HMIS/CNAA FORMATS	A 10.3.2	Nos	5	11.10 lakhs	55 LAKHS
2	TRAINING PROGRAMME	A 10.3.3	Nos	35,000	140 programmes	50 LAKHS
3	EVALUATION STUDY	A 10.3.4	Nos	10,00,000	2 studies	20 LAKHS
			Publicati- on of Reports	10	-	20 LAKHS
4	INFRASTRUCTURE SUPPORT	A 10.3.5	Nos	lumpsum	Computers, Printers, UPS, Outsourced vehicle & Recurring Expenditure	15 LAKHS
	<b>TOTAL</b>					<b>200 LAKHS</b>

**BUDGET OF DEMOGRAPHIC & EVALUATION CELL FOR 2009-2010 PIP**

**LINE ITEM A-10.3**

<b>MAJOR HEAD</b>	<b>MINOR HEAD</b>		<b>BUDGET IN (RS IN LAKHS)</b>	<b>DETAILS</b>	<b>REMARKS</b>
STRENGTHENING OF M & E /HMIS	SALARIES OF M&E MIS AND DATA ENTRY CONSULTANTS	1.1			
	MOBILITY FOR M & E OFFICERS	1.2	5.00		ADDITIONAL VEHICULAR SUPPORT (OUT SOURCEING) FOR D&E CELL TO TAKE UP EVALUATION WORK AND MONITORING
	WORKSHOP/TRAINING ON M&E	1.3	10.00		
	M & E STUDIES	1.4	40.00		IN HOUSE EVALUATION WORK ON PROGRAMMES AND ALSO EXTERNAL EVALUATION ON SOME OF THE ON GOING SCHEMES
	OTHER (SPECIFY)	1.5			
PROCUREMENT OF HW/SW AND OTHER EQUIPMENTS	HARDWARE/SOFTWARE PROCUREMENT	2.1	5.00		COMPUTERS, PRINTERS, SCANNERS AND LOGISTIC SUPPORT REQUIRED FOR IT
	INTERNET CONNECTIVITY	2.2			

	ANNUAL MAINTENANCE	2.3	2.50		AMC FOR ESTABLISHED INFRASTRUCTRE AND RECURRING EXPENDITURE
	PRINTING AND COMPUTER STATIONERY	2.4	2.50		
	OTHER (SPECIFY)	2.5			
OPERATION A-LSING HMIS AT SUB- DISTRICT LEVEL	REVIEW OF EXISTING REGISTERS-TO MAKE THEM COMPATIBLE WITH NATIONAL HMIS	3.1	40.00		ELIGIBLE COUPLE REGISTER IN NEW FORMAT OF A3 SIZE WHICH WILL BE COMPATIBLE WITH NATIONAL HMIS
	PRINTING OF NEW REGISTERS/FORMS	3.2	55.00		PRINTING OF HMIS FORMS AND CNAA FORMS FOR CNAA SURVEY
	TRAINING OF FIELD STAFF	3.3	40.00		FOR CONDUCTING CNAA SURVEY TRAINING AT DISTRICT, DIVISIONAL AND TALUKA LEVELS
	<b>TOTAL</b>		<b>200.00</b>		

## **HMIS:**

### **STRENGTHENING OF COMPUTER CENTRE AT RCH IN NRHM WING**

#### **Modernization of Computer room:**

**175. Infrastructure** :- Including consumables, cartridges, CD's etc. Hiring a vehicle for local and District visits. At a cost of Rs. 5.00 Lakhs Many IT infrastructure has been provided to Programme officers under NRHM. This includes computer (Desktop and Laptop) printer, Internet connectivity etc. A Separate computer centre also exists under RCH programme under NRM which cater to the needs of peoples coming from districts and Talukhs Health offices, and also to the other staff working in the Directorate and NRHM. The arrangement of system is not very adequate. Hence, a proposal for modernizing the centre is proposed at a cost of Rs. 15.00 Lakhs which includes partitions, blocks, electrical wiring and other infrastructures.

#### **Hardware Upgradation:**

**176.** Desktop computers and Laptop are provided to all the programme officers. As and when it is required the specification are to be upgraded. New printers are to be provided in place of old printers. Internet connectivity is to be provided to each programme office by providing Modem, Cables, etc. There are about 50 computers, printers to be upgraded under NRHM. This is proposed at a cost of Rs. 10.00 Lakhs.

#### **Leased Line for Internet Connection:**

**177.** Internet access and communication through e-mail is becoming the art of any management today. Without internet communication and data transfer is very difficult. Hence, a high speed leased line can be procured for the computer centre. Through Local Area Network all those computer under NRHM can access

internet easily without any additional cost. Maintenance of the connectivity and Management will be very easy. Speed also will be very good. This is proposed at a cost of Rs. 6.00 Lakhs. (3.00 Lakhs for the initial deposit and monthly rent @ Rs. 25,000/month, 3.00 Lakhs for one year)

**Training:**

**178.**Even though computers are provided to most of the section in the Directorate & NRHM, they are not being utilized to the Maximum extent because of lack of training in using computers. Hence a training program to train all the officers and group 'c' officials in the Directorate including peoples working as contractual basis under NRHM in proposed. There are about 250 officers and officials to be trained at Directorate at the rate of 35,000/- per batch of 25 people for 5 days the total cost will come to 3.36 Lakhs (For 10 batches at 25 / batch)

**Human Resource for Computer Centre:**

**179.**Even though computer & Printers are under Annual Maintenance contract for maintaining the Local Area Network and simple day to day operation in the computer centre, and Hardware maintenance engineer is required. One additional Data entry operator for the computer centre for day to day typing and other work is also required. Also Group-D (Helper) is also proposed at a cost of Rs. 3.84 Lakhs.

**TABLE-31****BUDGETARY ESTIMATE FOR HMIS**

<b>Sl. No.</b>	<b>ITEM</b>	<b>Quantity</b>	<b>Unit Price</b>	<b>Total</b>
1	Infrastructure including Consumables, Cartridges, CD's etc. Hiring a vehicle for local and District visits	-	5.00 Lakhs	5.00
2	Modernization of Computer Centre	-	15.00 Lakhs	15.00
3	Internet Connection Leased Line			
	a. Initial Deposit	1	3.0 Lakhs	3.00
	b. Monthly Rent @ Rs. 25,000/- per month	1	3.0 Lakhs	3.00
4	Hardware Upgradation. (Upgrading old computer and printer, providing new software etc.)	1	10.00 Lakhs	10.00
5	Training (Training 250 officers & Officials in computer usage. 25 per batch, 10 batches)	10	35,000	3.50
6	Man Power-			
	a. Hardware Maintenance	1	15,000	1.80
	b. DEO	1	10,000	1.20
	c. Group – D	1	7,000	0.84
<b>Total</b>				<b>43.34</b>

## CHAPTER-14

### Behavioural Change Communication

#### 180.Introduction:

Under the National Family Welfare Programme, Information Education Communication (IEC) wing was established at Directorate of Health & Family welfare Services more than fifty years back. Since then, IEC wing has been carrying out planning, implementation and monitoring of IEC activities as per the guidelines of Govt. of India as the funds are released from Ministry of Health & F.W.

Over the years, new schemes / programmes initiated by the Govt. of India are being implemented by the IEC wing. As per the DLHS survey report, the awareness especially at the grassroots level has been good about small family norm, which shows that IEC interventions have percolated each and every soul. However, there are many new schemes need to be prioritized depending on the local needs, which are to be focused on priority basis. This calls for intra-department and inter-department convergence to disseminate IEC messages more effectively and efficiently under the flagship of NRHM.

Now, it is necessary to think beyond IEC. As IEC interventions have been found successful in creating awareness on various programme / schemes of the department and also gained good experience in achieving satisfactory results in certain of the components, still many things have to happen to the desired level. To achieve this, it aims at behavioural change of both service providers and beneficiaries. Therefore, as a second generation activity, **BEHAVIOURAL CHANGE COMMUNICATION** has emerged.

#### 181.Need & Importance

BCC is a process that motivates people to adopt and sustain the healthy behaviour and lifestyles. Sustaining healthy behaviour usually requires a continuing investment in BCC as part of overall health programme.

BCC helps in understanding the dynamics of health issues in terms of

- ◆ Causes of health issues
- ◆ Gender

- ◆ Possible health related behaviour (encouraging and discouraging)
- ◆ Social, economic factors
- ◆ Develop problem statement that summarizes the above points to address the problem

### **182.Strategic Approach of BCC**

- ◆ Segmenting target groups.
- ◆ Identifying BCC needs (Educational approaches).
- ◆ Addressing target groups as required for BCC.
- ◆ Suggest corrective measures, modify action plan and implement.
- ◆ Document evidence based best practices.
- ◆ Monitoring and Evaluation.

The strategic approach will keep the above issues in the operational frame work for BCC / IEC interventions. It is important to concentrate on the minority communities, nomadic tribes etc which include the following;

- Minority communities such as koravas, gollas, bedars, lambanies, akki pikkies, dombaru, vaddars and other nomadic tribes. (example; The tradition of keeping the mother and new born outside the village / hamlet up to three months still prevailing in some minority communities). Lactating mother has to cook and look after the new born up to three months by herself)
- Fishermen in coastal districts.
- Siddis in Uttara Kannada district. (Siddis are found in the revenue villages as well as in their own habitations)

Apart from the above, there may be other minority groups across the state. The district health authorities need to identify them and prepare separate BCC programmes (any modifications planned required to be informed to the Mission Director (NRHM) in writing) for them followed by service facilities. The broad frame work for BCC approach remains.

In the areas, where health functionaries are not available, the district health authority needs to prepare “**Area Specific Approach**” plan to generate demand to access the service facilities through BCC interventions either through Mobile Medical Unit or Health Team comprised of medical, paramedical and non-medical staff to provide necessary health services facilities periodically.

Based on the situational analysis, the districts have to keep the above issues in view and plan, implement and monitor BCC activities. The outcomes BCC interventions should be evidence based which include the following;

- Reduction in Maternal Mortality Rate (MMR)
- Reduction in Infant Mortality Rate (IMR)
- Increase in institutional deliveries
- Increase safe deliveries
- Complete coverage of primary immunization
- Reduction in Total Fertility Rate
- Postponement of early marriage

Beginning of the year 2010-2011, it is necessary for the districts to have current status on the above health indicators, so that on quarterly basis, district can draw inferences on the outcomes on each of the health indicators. This method of monitoring will facilitate the district authorities to take up mitigatory measures to modify the BCC interventions to improve the quality of performance in achieving set goals.

### **183. Cross Cutting Issues**

In order to achieve the set goals, there is great need of convergence with other line departments. These line departments are providing services to the communities which have bearing on health of women and children in particular and communities in general either directly or indirectly. Some of the cross cutting issues which include the following;

- Safe drinking water and improved sanitation
- Safe disposal of household solid and liquid wastes

- Household latrines and community latrines
- Promoting washing hands with soap after defecation, after disposal of child excreta, before feeding, cooking and serving
- Smokeless chullas
- Encouraging in promoting iodized salt in local shops
- Prevention & control of fluorosis
- School Sanitation and Hygiene Education & promoting bio-fencing to schools through NREG

If the above issues are given importance by the department functionaries with the help of concerned line department functionaries by way of convergence, definitely there is great scope for overall development of health status of the community. This will also save money, time and duplication of work. At this juncture, it is needless to mention that Joint approach will definitely exert influence in the minds of the individuals in particular and community in general.

Keeping these in view, proposed Action Plan for 2010-2011 is prepared which gives the details of man power, equipment, development and procurement of IEC materials (print & electronic) IEC / BCC interventions, workshops, capacity building, Training of Trainers (TOT), sensitization workshops at various levels for different category of functionaries. It is to be noted that all field functionaries and other officers require IEC materials for their day today activities as well as capacity building programmes at various levels. The details of activities planned for State and District levels are given in the PIP for 2010-2011.

**Table-32**

**QUARTERLY BUDGET ALLOCATIONS UNDER BCC**

SL.no	Detailed Activities	Quarterly budget allocations				Total (Rs. In lakhs)	Remarks
		Q1 (Rs. In lakhs)	Q2 (Rs. In lakhs)	Q3 (Rs. In lakhs)	Q4 (Rs. In lakhs)		
1	Setting up and development						

	of IEC/BCC unit at the state level/ district level						
1.1	Meeting <b>Manpower requirements</b> at state level						<b>To be borne under SPMU Budget</b>
1.2	Meeting <b>Manpower requirements</b> at district level						
1.2.1	Data Entry Operators- 29x 12xRs. 4,000/-	3.48	3.48	3.48	3.48	13.92	
2	<b>Formative research/</b> situational analysis/ baseline study to identify focus areas	15.00	20.00	20.00	20.00	75.00	M/s. Faith Health care agency has been hired and the work is under way.
3	<b>Develop IEC/ BCC strategy</b>  Streamline objectives/ identify communication tools/identify media mix as per target audience/ frame monitoring evaluation indicators  Identify external agency / <b>Advertising agency</b> for the task  (if needed)	8.00	8.00	8.00	8.00	32.00	M/s. Faith Health care agency has been engaged for this task.
						120.92	
4	<b>Media Mix</b>  Develop a strategic media mix as per the target population and issues (Child Health, Maternal Health/ Family Planning)						
a)	<b>Interpersonal communications</b>						
	MH-Sensitization training on		11.00	11.00	11.00		

	NRHM for GP, TP members, Anganawadi workers, Jr. HA (M&F) and ASHAs through satellite. 3 programmes x Rs. 11.00 lakhs per programme	0.00				33.00	
	CH- Capacity building on IEC/BCC through TOTs and Roll outs (10TOTs - 3 days @ Rs. 500/- x 40 persons x 2 Batches	3.00	3.00	3.00	3.00	12.00	
	CH-Roll-outs 4 batches x 40 members x 29 Districts x Rs. 400 per person. Sr. HA (M&F), BHEOs & ICDS Supervisors	4.64	4.64	4.64	4.64	18.56	
	<ul style="list-style-type: none"> <li>• Group discussions at village/ block/Panchayat level</li> <li>• Community meetings</li> </ul>						<b>Through DTC</b>
	1. High intensity campaigns at sub centre level on themes like						
	a. FP-NSV and male participation Rs. 175 x8000 sub centres	0.00	5.00	4.00	5.00	14.00	
	b. FP-Gender equity and Status of women and age at marriage@ 175 x8000	0.00	5.00	4.00	5.00	14.00	
	c. CH-NRHM schemes like JSY, Madilu etc. @ 175 x 8000	0.00	5.00	4.00	5.00	14.00	
	CH-ZP President and Vice president workshop on NRHM at State level	0.00	9.00	9.00	0.00	18.00	
	CH-Sensitization training for Minority Communities @ Rs. 2,000/- each x 400 (Gollas, Hakki pikkaru, Dombaru and others - Special 7 Districts).	0.00	1.00	1.00	2.00	4.00	

	<b>FP-Two special focused Conference on age at marriage theme for Northern region elected representatives including MPs, MLAs, ZP, TP and other elected representatives at Regional level.</b>  Rs. 8.00 lakhs per programme	0.00	0.00	8.00	8.00	16.00	
						143.56	
<b>b.</b>	<b>Community media FP</b>						
	• Folk artistes' workshop						
	<b>FP-Regional level folk artistes' workshop (3 days)</b> 4 workshops x Rs. 3.00 lakhs	6.00	6.00	0.00	0.00	12.00	
	• Street plays / Folklore	4.13	4.13	4.13	0.00	12.41	
	<b>FP-World Population day at,</b>						
	State-1	12.19	0.00	0.00	0.00	12.19	
	District-1	2.90	0.00	0.00	0.00	2.90	
	• <b>FP-Rallies</b>						
	<b>FP-Intersector Convergence workshop at District level</b>  Rs. 25,000 x 29 Districts	0.00	2.50	2.50	2.50	7.50	
						47.00	
<b>c)</b>	<b>Outdoor media</b>						
	<b>CH-Bulletin boards and Display boards at all Districts, Taluks and PHCs through V-SAT</b>	9.00	9.00	9.00	9.00	36.00	
	<b>FP-Major Exhibitions including Mysore Dasara.</b>	0.00	0.00	3.00	0.00	3.00	

	CH-Advertisements through CCTV coverage	5.00	5.00	5.00	5.00	20.00	
<b>d)</b>	<b>MH- Television spots</b>						
	Production and Procurement of 20 themes of NRHM, RCH, FP and National events.	0.00	7.50	7.50	0.00	15.00	
	Telecast charges on Doordarshan and Private channels	7.50	7.50	7.50	7.50	30.00	
	CH- Procurement & telecasting charges on DD & Pvt. Channels	0.00	2.44	0.00	0.00	2.44	
	FP- Procurement & telecasting charges on DD & Pvt. Channels	3.00	3.00	3.00	3.00	12.00	
<b>e)</b>	<b>MH-Radio programmes</b>						
	Script Development workshop (Print and Electronic)	0.00	2.00	2.00	0.00	4.00	
	Production and Procurement of Radio dramas / Radio lessons/ Radio Jingles etc on 20 themes	5.00	5.00	5.00	0.00	15.00	
	Broadcast charges on AIR and other pvt. Channels	5.00	5.00	5.00	5.00	20.00	
						133.00	
<b>f)</b>	<b>FW-Newspaper advertisements</b>						
	Development of Proto types and to advertise on newspapers and periodicals on 20 themes of NRHM, RCH, FP and National events	9.00	9.00	9.00	9.00	36.00	
<b>g)</b>	<b>CH-Print materials</b>						

	<b>Development of Proto type print materials on 20 thematic areas in following formats</b>						
	FP-Folders (2 types)	5.00	5.00	5.00	5.00	20.00	
	CH-Posters (4 types)	5.00	5.00	5.00	5.00	20.00	
	MH-Flip book on Antenatal, post natal and neo natal care and Family Welfare 1 flip book	132.10	0.00	0.00	0.00	132.10	
	CH-25 Episodes Serial documentary film on NRHM	20.00	20.00	0.00	0.00	40.00	
	FP-Calendars and danglers	0.00	0.00	0.00	5.00	5.00	
						271.00	
	<b>BCC implementation components</b>						
<b>6)</b>	<b>Capacity building and training of manpower</b> (Designate responsibilities as per task/Identify coordinator and design activity chart)						
	FP-Capacity building of BHEOs, DyHEOs and DHEOs on Developmental Communication at Specialized institutions	0.00	10.00	10.00	10.00	30.00	
	MH-Exposure Visits for Journalists to best 24 x 7 PHCs	0.00	0.00	2.90	0.00	2.90	
<b>7)</b>	<b>CH- Monitoring and evaluation</b>						
	Midterm / Concurrent & Terminal monitoring	0.00	0.00	0.00	15.00	15.00	
						47.90	
<b>8)</b>	ARSH	0.00	5.04	5.04	0.00	10.08	

	<b>Total quarterly Budget</b>						
	<b>Total BCC/IEC Budget</b>					<b>780.00</b>	

## CHAPTER – 15

### QUALITY ASSURANCE

#### **Background**

**184.** Consensus on the importance of quality of care in population programmes emerged in the International Conference on Population and Development (ICPD) held in Cairo in 1994. Provision of package of quality reproductive health services and addressing unmet reproductive health needs of the couples and individuals became the central theme. Quality of care (QOC) was perceived as an integral and major component of people's reproductive rights. This was considered as a landmark development wherein there was a paradigm shift from a demographic approach to responding to the reproductive health needs of the clients.

**185.** There has been some attention to monitor service quality in the RCH 1 project in form of tools and Checklists. **However information from the districts indicate that routine supervisory visits did not provide adequate opportunities to monitor service quality and invariably these visits were rushed in nature.**

#### **The Present Setting**

**186.** The Monitoring & Evaluation Strategy of Ministry of Health and Family Welfare (MOHFW) for the National Rural Health Mission (NRHM) and Reproductive and Child Health Programme II (RCH II) envisage assessing the quality of RCH service as an important strategy element. Tumkur District was selected as a pilot District for the QAP during the year 2007-08. The Population Council has been hand holding/providing TA (Technical Assistance) to institutionalise the QAP. The outcome of the QAP has been very encouraging after the completion of II Phase of QA visits. Hence it was decided to include 5 more Districts of the State during the year 2008-09. **viz. Koppal, Kolar, Haveri, Chikkamangalore Bijapur. And 2009 PIP Included six district Gulbarga, Chitradurga, Gadag, Raichur, Bidar Bellary, 2010-11 PIP Included six more districts, Chamaraajanagar ,Belagum, Mandya, Shimoga, Uttara kannada and Udupi**

The Quality Assurance Programme is made up of two main components:

- **Quality Assessment**
- **Quality Improvement**

The objective of the proposed Quality Assurance mechanism at district level management is to facilitate the continuous monitoring of quality of reproductive health services at Sub centers, CHCs/PHCs and RCH camps and consequently improve service quality by focusing on the gaps identified during the assessment process. In order to do this, it is proposed to set up a District QA group within the public health system consisting of district programme managers who will conduct periodic assessment visits using specific tools and based on the gaps identified; help the service providers address specific service quality elements and sub-elements. Details of the activities of the QA group have been provided the manual supplied to the District already.

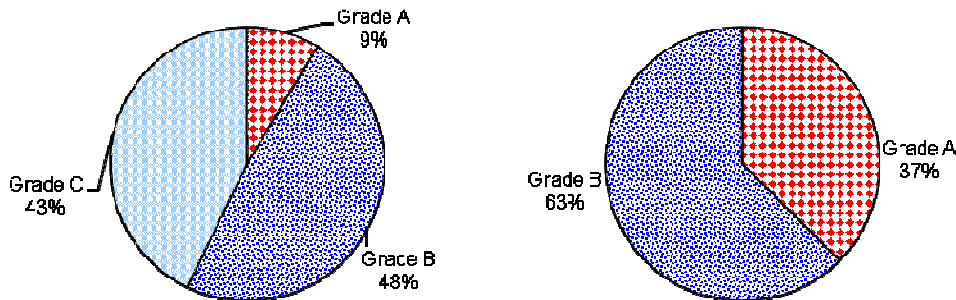
**Tumkur District observation(QAP started on 2007)**

Diagram-7

Overall Grades of CHC/PHCs in First and Second Round of QA Visits

First round of QA visits (n=35)

Second round of QA visits (n=16)

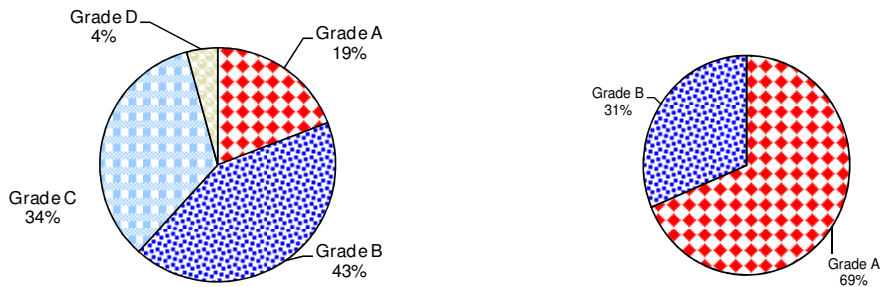


The overall scores for sub-centers revealed that while majority of sub-centers were in B or lower grades during second more than thirds (69 percent) of sub-centers scored A grade Diagram-8

**Diagram-9 Overall Grades of Sub-centers in First and Second Round of QA Visits**

First round of QA visits (n=47)

Second round of QA visits (n=16)



At individual facility level analysis shows that all the facilities in the district scored higher grades during second visit as compared to their corresponding grades obtained in the first visit. Average score of the facilities visited increased by 25 percent points in CHC/PHCs (from 49 to 74 percent) and 27 percent points in sub-centers, from 53 to 80 percent.

To get insight into the gaps causing lower facility grades, the ‘input’ and ‘process’ scores have been separately analyzed and presented below. The elements relating to facility readiness such as, human resources, infrastructure, equipments and supplies and availability of service delivery protocols have been grouped together as ‘inputs’. Similarly, the elements relating to the service delivery environment and procedures are have been grouped together as ‘processes’. These include cleanliness, infection prevention practices, maintenance of records and maintaining the hygiene and asepsis among others.

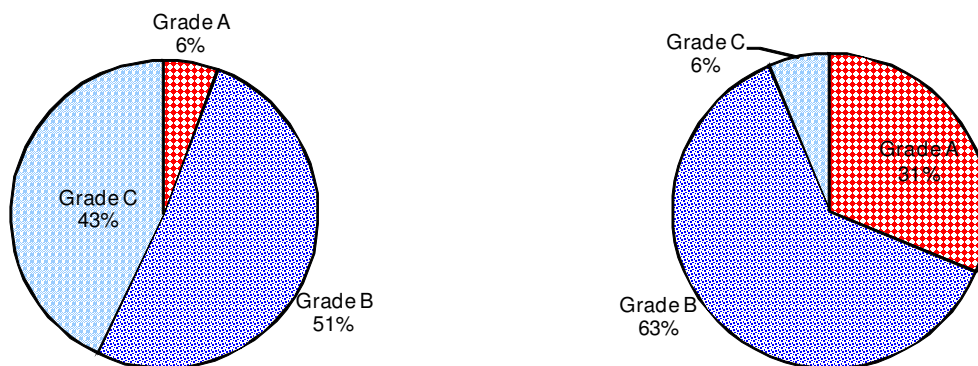
**Inputs:** The analysis of input grades of CHC/PHCs shows facility readiness and availability of human resources to provide quality RCH services have improved significantly in the district between first and second round of visits. While during first round of visits, only 6 percent of CHC/PHCs scored input grade A, it increased to 31 percent in the second round of visits (Figure 5). The facilities scoring C grade reduced from 43 percent in the first round to 6 percent in the second round.

Diagram-10

Input Grades of CHC/PHCs in First and Second Round of QA Visits

First round of QA visits (n=35)

Second round of QA visits (n=16)



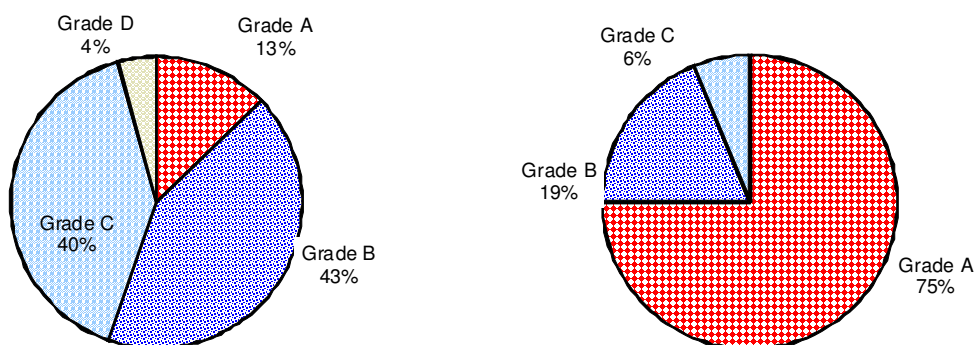
The inputs score of sub-centers also increased significantly in between first and second round of visits. While during first round majority of sub-centers (87 percent) scored B grade or lower, three-fourths of them achieved A grade during second round of visits

Diagram-11

Diagram-12 : Input Grades of sub-centers in First and Second Round of QA Visits

First round of QA visits (n=47)

Second round of QA visits (n=16)



### **State's Decision to Scale-up the QI initiative Some More Districts**

Impressed by the QA visits bringing improvements in quality of service delivery, Principal Secretary, Health and family welfare, Government of Karnataka has decided to scale-up quality improvement activities in the entire state in the phased manner. As the first step, the state health department has decided to scale-up the QA program 2008-09 five more districts of Karnataka and 2009-10 six districts were included.

**Conclusion:** Readiness (infrastructure supplies and trained human resources) of the health facilities at all level has shown significant improvement which is an important requisite for providing quality services. The process component which actually address to the quality of delivering services has also shown improvement but at a lot more initiative from district health management is required. It is primarily because it demands behavioral change, adherence to clinical standards and adoption of good practices. To accelerate the improvement in the processes, supportive supervision need to be strengthened and more attention should be given to review the process part.

Scaling up of quality improvement initiatives to five more districts of Karnataka shows state health department's commitment to provide quality services from public health facilities in the entire state. The state health department has requested for TA from Population Council to scale-up the QA program in these five districts. Population Council is willing to provide the TA to state but the resources required for TA provision need to be worked out. We feel that either the Ministry of Health and Family Welfare should allocate the resources for TA in the NRHM program implementation plan or the ministry collaborates with the donor agencies to support the TA cost of Population Council staff.

Integration of the QA program with DPIIP and drawing resources from NRHM to conduct QA activities is an important achievement. It ensures that available fund with state/district/facility level is being used for improving the access and quality of services.

2010-11 included Six more districts, Chamarajanagar ,Belagum, Mandya, Shimoga, Uttara Kannada and Udupi. **Quality Assurance Programme Budget: 108 lakhs**

## **CHAPTER-16**

### **TRAINING**

**187.** Medical and health field is one of the fastest changing areas where updating health workers about the newer development in their service delivery is mandatory for effective and ethical health services to community. Training is one of the critical components of health programs and health initiatives. Goal and objectives of the national health policy and the MDGs are also focuses on capacity building of the existing health workers to achieve desired results.

**188.** National Rural Health Mission has set in motion a process of decentralized and horizontal integrated implementation of the disease control as well as administration of Family Welfare Programmes through convergence of activities related to various departments like WCD, Drinking water, Sanitation for provision of integrated health and family welfare, nutrition and sanitation services for the community. In this regard a paradigm shift in training from vertical training programme to integrated programme focusing on skill upgradation for all national health programme is envisaged under NRHM in order to improve efficiency and effectiveness of training and to facilitate the out come of improving, quality and coverage of services.

**189.** National Rural Health Mission envisages providing affordable, equitable and quality health care to the population, especially vulnerable group. A major pre-requisite for providing quality health care is upgrading the skills and knowledge of all health personnel as well as key personnel of related sectors. Capacity building is taken as one of the associated activity in implementing and functionalizing the NRHM goals. Various functionaries in the department of Health and Family Welfare are sensitized, trained and re-oriented there by upgrading the skills and knowledge in management, communication and clinical services.

#### **3.8.1. Objectives of the in service training:**

- Up grading the skills and knowledge of all health personnel as well as of key personnel of related sectors so as to provide quality health care.
- All the health care personnel in the district acquire skills and knowledge to provide the health care services effectively and efficiently.

- All the health care personnel develop the knowledge of the linkages between the various sectors dealing with health determinants for provision of integrated services.
- Enabling the Medical and Para Medical staff to develop necessary skill for delivering the maternal health, child health, Family Planning, Disease Control Programmes and other newer initiatives under NRHM at different health institutions and community.
- Enabling the Medical Officer of the Primary Health Center and other supervisory staff at block and district level in developing the leadership quality so as to make the staff work as a team and serve the community.
- Enabling the Medical Officer of the Health Center in effective management of Finances and other logistics at different level of activities.

#### **190. Situational Analysis:**

Main goal of NRHM is being to provide effective, affordable qualitative and comprehensive health services to rural and tribal poor and also to most vulnerable and under served population through functional health facilities; that is 24x7 PHC's, FRU's and through out reach activities. Keeping these key points in mind, for last 4 years capacity building of the health care providers working in the above facility were trained in various skills, knowledge required to deliver maternal health care, child health care, family planning services and adolescent health care and other required programmes. These functionaries were also motivated to work in the rural areas. Annexure 1 shows year wise progress of training for last 4 years of NRHM period.

Karnataka State has good infrastructure net work for the training within the department of health family welfare and also in private sectors. Table below gives the details of infrastructure available in the state both public and private. Medical colleges are functioning as Regional Resource Centres for various trainings. .

Training achievements									
Trainings	Category	Total Training Load	Achievement for years (Don't give cumulative data, please give year wise specific achievements)					Proposed training Load for 2010-11	Remarks
			2006-07	2007-08	2008-09	2009-10 ( nov)	Cumulative Total		
SBA	MO	2300	152	101	0		253	750	
	Staff Nurses	4500	28	500	1900	1076	3504	1500	
	ANM/LHV	4400	0	40	248	481	769	1200	
	AYUSH	400				146	146	300	
EMOC	MO	108	0	0	24	16	40	56	
LSAS	MO	108	0	41	12	18	71	36	
Blood Storage	MO	192					0		
	LT	192							
MTP	MO	350	59	74	62	42	237	80	
IMNCI ANMs	ANM/LHV	10000	86	100	1000	998	2184	1000	
IMNCI MOs	MO	2200		131	186	384	701	750	
IMNCI SN	SN	4500				308	308	1000	
IMNCI AWW	AWW	52000	0	402	3464	5727	9593	3000	
F-IMNCI	MO	2200					0	2200	
SNCU	MO	51					0	36	
	SN	204						3600	

IUD	MO	2200	0	34	58	466	558	480	
	SN/LHV	4500	0	167	93	906		1920	
	ANM	9000	402	213	680	1212		3000	
Mini Lap	MO	1200	35	129	92	57	313	60	
Lap	MO	300	27	23	30	31	111	30	
NSV	MO	300					0	300	
RTI/STI	MO	1200					0	450	
	SN	3600					1405	1000	
	LT	1200					499	450	
ARSH	MO	1000			492	479	971	1500	
	Health Workers	9000						2700	
	ASHA/AWW/School Teacher	52000						40000	
Immunization	MO	3200		565	334	0	899	500	
	Health Workers	15000		1237	12120	0	13357	500	
ASHA	ASHA	39000	0	1000	10000	10500	21500	8000	
IDSP	MO/Health workers/Lab Technician	13940	1782	11391	230	0	13403	300	
RNTCP	MO/Health workers/Lab Technician						0		
NLEP	MO/Health workers/Lab Technician	6000	0	2957	1498	0	4455	1000	
NBCP	MO/Health workers/Lab Technician	1000		180		0	180	500	
NRHM trainings	MO/SN/Health workers/ Health Education personale/ other related departmental personale	15000	1764	6982	2543	0	11289	0	

PDC trainings	MO	100		40	15	0	55	30	
HIV/AIDS	MO/Lab Tech/ Health workers	1500	0	0	1300	0	1300	will be projected by KSAPS	
Mental Health	MO/Health workers	10000	0	9018		0	9018	500	
Induction Training : under 12th Finance	MO/Other paramedical staff	3000	0	2489	0	0	2489	1500	
Computer Training: under 12th Finance	MO/ Health workers/Ministreal staff	1000	0	0	628	60	688		
Special skill training	SN/ MO/ Specilist: under 12 th finance scheme	500	0	192	3	3	198		
other Management training: under 12th finance scheme	MO/ Administrative officers	7000	366	225	6287	90	6968		
ICDS trg: state funds	MO	200	0	85	32	30	147		

Basic information									Proposed year			Theme/Health indicator/ Data/ DPs	
1	2	3	4	5	6	7	8	9	10	11	12	13	16
Sl No.	Name of the Training Programme	Category of Staff to be trained	Total Training Load	Trained till 31st Dec 09 (Cumulative total since the	Number of Facility operational as per GOI norms in relation to	Training load projected for year	Trained during Mar -Dec 09 (Training Achievement in current	Number of Facility operationalized in 09-10 (updated till 31 Dec 09,	Training load projected for	Proposed Number of Facility to be operationalized as per GOI norms year 10-11	Time line for Saturation of trainings in states (years or months)	NRHM theme for year 10-11 linked with this trainings	Name of DPs supporting in
1	SBA	ANM	4400	940	940 SC	1000	481	481 SC	1000	1000 SC	2 yrs	Provision of quality care by the SBA trained Staff	
		SN	4500	3792	940 PHC's	1000	1076	940 PHC's	1500	80 PHC's and 192 FRU's and some from DH	1 yr	safe and quality services at PHC's and FRU's there by reducing the maternal and neonatal morbidity and mortality	
		MO	2400	0		750	0	0	750	750 PHC's	2 yrs		
2	EMOC	MO	108	40	192	40	24	24	40	40	1 yr	EMOC at FRU	

3	LSAS	MO	108	61	192	54	18	18	32	32	1 yr	EMOC at FRU's	
4	Blood Storage	MO	192										
		LT											
5	MTP	MO	350	140	140	100	42	42	100	100	3 yrs as it is on going trg	safe abortion services at CHC, TH and DH without OBG specilist	
6	IMNCI	MO	2200	900	900 PHC's	750	384	384	750	750	2 yrs	quality neonatal and child care	
		SN	4000	308	100 PHC's	1000	308	100 PHC's	1000	300 PHC's	3 yrs as it is on going trg	quality neonatal and child care	
		ANM/LHV	5000	2000	2000 SC	1000	998	998 SC	1000	1000 SC	3 yrs	quality neonatal and child care	
		AWW	23000	8000	8000 AWW	5000	5727	5727 AWC	3000	3000 AWC	3 yrs		
7	F-IMNCI	MO	2200	0	0	300	0	0	1000	1000 PHC's	2 yrs	facility care to sick new born and children	
8	SNCU	MO	51	0	0	0	0	0	51	17 DH	1 yr	Sick neonatal	

												care at DH
		SN	204	0	0	0	0	0	204	17 DH	1 yr	
9	IUD	MO	2200	558	558 PHC/ CHC	750	466	466 PH C/C HC	480	480 PHC and CHC	2 yrs	quality Iud service and there by increasing the increase in spacing methods
		SN/LHV	4500	1169	558 PHC/ CHC	1000	906	558 PH C and CH C's	1920	480 PHC and CHC	2 yrs	
		ANM/ LHV	8413	2500	2500 SC	1000	1212	1212 SC	3000	3000 SC	2 yrs	
10	Mini Lap	MO along with team of SN and OT attende r	500	313	313 PHC/ CHC/ FRU's	200	57	57 PH C/C HC/ FR U	60	60 PHC/C HC/FR U	3 yrs	quality FW services
11	Lap	OBG/S urgeon with team	350	111	111 FRU's	36	31	31 FR U's	30	30 FRU's	3 yrs	quality FW services
12	NSV	MO										
13	RTI/STI	MO	2200	0	0	0	0	0	1200	1200 PHC's	1 yr	complete quality RTI/STd service including

												treatment of partner
14	ARSH	MO	2200	987	987 PHC's	1000	495	495 PHC's	1500	1500 PHC's	1 yr	provision of ARSH services at PHC
		Health workers: ANM/LHV/HWM/BHEO	120000	0					2700	1500 PHC's	2 yrs	Provision of ARSH services at SC
		ASHA/AWW/School Teacher	700000						400000		2 yrs	Awareness craetion to Adolescents in the community
15	Immunization	MO/Health workers	1500000	12400					2600000		1 yr	Quality and quntitaive Routine Immunization programme
16	RNTCP	MO/Health workers /LT										
17	NLEP	MO/Pharmacist / Health supervisor	1000000	4455	2193 PHC's	0	0	0	2000			
18	NBCP	MO/Health workers /LT	2000	180					2000			

19	NVBDC P	MO/Health workers /LT	10000									
20	IDSP	MO/Health workers /LT	13800	13173	2193 PHC's and 8143 SC	0			2000			

## Financial Progress from March 2006 to Nov 2009

Financial Progress for the year 2006-07		Financial Progress for the year 2007-08		Financial Progress for the year 2008-09		Financial Progress for the year 2009-10 till November 2009	
Budget Allotted	Expenditure	Budget Allotted	Expenditure	Budget Allotted	Expenditure	Budget Allotted	Expenditure
396.95	114.53	802.5	474.37	536.12	423.43	1306.34	473.51

### 191. Training strategies as per the national guidelines:

Present strategy looks at the paradigm shift on the following issues:

- Paradigm shift from vertical training to integrated training
- From knowledge transfer to skill up gradation
- Training being linked to facilities which are functional/ being made functional
- Convergence with related departments
- Institutionalize training planning from sub center up wards
- Focusing on the priority theme and key area for actions namely underserved population comes under Backwards, Minorities, tribal and SC/ST and gender specific concern

### 192. Implementation plan for training for the year 2010-11:

- Trainings are mainly focused on districts needs in the field of bringing down morbidity and mortality among pregnant and post natal mothers, children mainly the neonates , adolescents who are future parents and general population.

- During the year 2010-11, seven high focused districts as per GOI guidelines (Raichur, Bidar, Bellary, Chamarajanagara, Chitradurga, Davangaere and Kolar) and 5 more C category districts ( Gulbarga, Yadgir, Koppal, Bijapur and Bagalkot) and 1 tribal- Kodagu are given more priority and a special action plan is been developed in implementation of trainings.
- Health functionaries working in these districts are trained on priority so as to functionalize the facilities available in these districts.
- Health care providers from other areas are also trained as per the district requirement.
- State Institute of Health and Family Welfare, Bangalore works as the nodal center for planning, budgeting, monitoring and further facilitating the districts to utilize the trained health personal at appropriate places. District training Centers along with Regional Health and Family Welfare Training centers and Pre service ANM training centers are working with the SIHFW in implementing the trainings at districts and sub district level.
- Medical colleges, other non governmental institutions, NGO's having experience in the field of public health are working with SIHFW as Regional Resource Centers and in mentoring and providing required expertise in various field. And these institutions also provide the expertise in monitoring and evaluation of trainings at various level.
- Trainings are developed as per guidelines Government India, WHO and UNICEF. Standard Operating Procedures are developed based on various standard guidelines provided by WHO, GOI and UNICEF.
- Various training methodologies are followed keeping in view the Adult Learning Principles. Training manuals developed by GOI are translated in to local colloquial language are used and distributed to each and one of the trainee.
- Financial guidelines for the training is followed which is been prescribed by the GOI with few modification required locally.

**Capacity of the Training Institutes is non-negotiable element**

**Information about training reports and feedback system**

<b>Activity</b>	<b>For all trainings altogether i.e. centralized training coordination</b>	<b>For specific trainings IMNCI/ SBA/ MTP/RTI-STI/ ARSH / IUD / NSV and other trainings</b>	<b>Remarks should briefly describe the process here or in separate descriptions</b>
State Level training team	SIHFW works as centralized training coordinator	State team including Faculty from Medical college, SIHFW, Other public health institutes who have under gone TOT's	
District Level Training Team	DTC along with help of the Medical college and District hospitals works as district team	TOT's of each training	
State Training Cell or Division in place	SIHFW	Each Deputy Director of the SIHFW Nodal officer for each programme	
District Training Cell or Division in place	DTC/ HFWTC	Principal DTC / HFWTC nominated as Nodal Officer	
State level analysis of training reports	By SIHFW	Monitoring of training by the Deputy Directors of SIHFW	Training report as per the NIHFW format will be analysed
District level analysis of training reports	DTC/HFWTC		Through quarterly review meeting
Regular feedback from state to district regarding trainings			
State Level Training supervision and monitoring mechanism (QAC*) in place	SIHFW		<b>Y using check list</b>
District level Training supervision and monitoring mechanism in place	DTC/HFWTC/ District team		By using check list

Training infrastructure information

IT	Government	Private / NGO	Total	Total Capacity of the Institutes*	Remarks **
SIHFW CTI	1	Nil	1	Fully Functional	
State Level Public health training institutes		2	2	Fully Functional	i.e. IIHMR,
HFWTC	4	0	4	Fully functional	
Nursing Training School	11	250	261	functioning with hired faculty	
ANMTC	29				
MPWTC	4	0			
District Training Centre	19	0	19	Functioning with hired faculty	
Block Training Centre	146				At block level trainings are conducted through Taluk and Sub taluk hospitals , mainly under skill based trainings
Other training Centre	4 to 5				IIM, IHMR and PHI are the institutes extending their facility for the trainings, mainly for Management trainings
Public health institutions in states					
Medical Colleges	10	23	33	Fully Functional	
Paramedical Institutes					Gives specialty wise details

### Infrastructure available for Training:

**Table Showing the Training Institutions in the state with staff and Infrastructure available**

Sl No	Name of the Institution	No	Faculty	Infrastructure	Remarks
1	SIHFW	1	Director, Joint Director, 10 Deputy Directors and supporting staff	1 Administrative Block and 1 Training Block with 1 Conference Hall, 5 class rooms with LCD, Over Head Projector, Slide Projector, well equipped library and Hostel facility for 35 members.	Need for Up gradation and renovations
2	HFWTC	4	Principal, MLCD, Epidemiologist, Communication faculties and supporting staff	3 Class rooms, with all teaching aids, library and field demonstration station, Bus and jeep/ tracks. In house facility for 40 members.	
3	DTC	19	Principal, HEO and DNO and supporting staff	1 class room, and in house facility for 30 persons with library and all teaching aids.	
4	ANMTC	28	Principal, 6 tutors with supporting staff	1 class room, in house facility 40 trainees, library with adequate teaching aids	
5	LHVTC	4			
6	District Hospitals	26	TOT trained OBG, Pediatrics, Skin specialists etc		For Hands on practice in skill Training

7	CHC, TH and GH	352	TOT trained OBG, Pediatrics, Skin specialists etc		For Hands on practice in skill Training & Field visits.
8	Medical college hospitals	30	TOT trained OBG, Pediatrics, Skin specialists etc		For Hands on Training

### **193. Proposed trainings and related activities for the year 2010-11:**

1. Infrastructure development
2. Training and Teaching Aids and development of training manual
3. Human resource required for the training Institutions
4. Trainings

### **194. Infrastructure development :**

1. Provision of Healthy , Hygienic and aesthetic environment for good quality learning
2. Provision and usage of modern teaching and learning aids, Library facility and required laboratory facility.
3. Development of manuals and literature required for training will be under taken through conducting workshop of subject specialist.

### **195. In sourcing of experts/ specilist as Resource persons.**

1. In sourcing of Specialists from various fields to provide required knowledge and skills to the designated/specified trainees, for pre-service and in-service course.
2. In sourcing of teaching faculty for the pre service training schools also will be done.

### **196. Training Strategies Proposed for the year 2010-11 :**

Health care providers are exposed to following trainings which are under taken through various programmes;

- **induction training** of various health personnel will be under taken for the period of 2 to 4 weeks at the time of entry in to service.

- **in service training** is the major component provided to all the categories of health care workers to up grade the skills and knowledge in technical and management fields.

- **Refresher training** is taken as continuous education for health care providers once in two years.

## **RCH II trainings:**

### **Maternal Health;**

#### **197. Specific Objectives:**

-up grading the skills and knowledge of health care providers in providing essential ANC, assessment of Labour using partographs, Active management of 3<sup>rd</sup> stage of labour using tab Mesoprostal, Prevention of Eclampsia by using Ing MgSO<sub>4</sub> in PIH cases, and Essential new born care at birth including resuscitation of the new born.

- up grading the skills and knowledge of the health care providers in early detection and complete treatment for the clients with RTI/STD.

**198. Out come:** Functionalizing all the identified PHC and CHC in providing 24x7 services, thus facilitating the districts to increase the institutional delivery to 85% by end of 2009-10, which further facilitates in reducing the maternal morbidity and mortality.

#### **Strategies:**

- **Skill birth attendance training;** to Medical officers, staff nurses and Head quarters ANM from each of the 24x7 PHC and CHC's including FRU's . The above functionaries will be trained at 42 identified centers at district and sub district hospitals which are Government, Private including Medical Colleges.
- **EmOc training and LSAS training** to MBBS doctors from needy districts will be given followed by posting and placing them at identified FRU where the specialist service of Obstetrician and Anesthesia are not available. Trainings are conducted as per the guidelines of GOI with help of FOGSI, Medical Colleges and district hospitals. Focus is given for skill development in obstetric care by exposure to sufficient number of deliveries cases.
- **Training in MTP by using MVA:** to provide safe abortion services at CHC and FRU's, Medical Officers from these institutions will be trained and they will be provided with required equipment after the training.
- **RTI and STI training** to MO, Lab technician, Staff nurses and field ANM will be under taken with the help of KSAPs and as per the NACO guidelines.
- **IMEP training:** Medical and paramedical personale working at SC, PHC, CHC and FRU's and also other major institution will be trained under Infection Management and environment pollution so as to manage the biomedical waste safely.

### **Status of FRU Operationalization**

SI NO	State	Total number of FRU's planned till 2010	Target for 2009-10	FRU's Operationalized till December 2009
1	Karnataka	192	192	142

#### Status of 24x7 PHC's

SI No	State	Total No of 24x7 PHC's Planned till 2010	Target for 2009-10	24x7 PHC's operationalized till December 2009
1	Karnataka	1200	974	974

#### Status of Anesthesia Training

SI No	State	No of Medical Colleges conducting LSAS Trainings	No of District Hospitals conducting LSAS Trainings	Total no of Doctors to be trained in LSAS till 2010	Target for 2009-10	No trained till November 2009	No of Mo's posted at FRU till November 2009
1	Karnataka	6	19	108	36	71	66

#### Status of EmOC Training

SI No	State	No of Medical Colleges conducting EmOC Trainings	No of District Hospitals conducting EmOC Trainings	Total no of Doctors to be trained in EmOC till 2010	Target for 2009-10	No trained till November 2009	No of Mo's posted at FRU till November 2009
1	Karnataka	1	10	108	36	40	38

### Status of SBA Training

SI No	State	No of Districts conducting SBA Trainings	No of District Hospitals/ training institutes practicing SBA protocols particularly Partographs	No of Master Trainers trained ( both State and District)	No of SN's/ANMs/LHVs to be trained till 2010	Target for 2009-10	No trained till December 2009
1	Karnataka	29	42	253	8000	3000	4000

### Status of MTP Training

SI No	State	No of doctors planned to be trained in MA/MVA/EVA till 2010	No trained till December 2009	No of 24x7 PHCs providing Safe Abortion Services	No of DH/ FRU providing Comprehensive Safe Abortion services
1	Karnataka	350	237	237	246

#### 199. Child Health:

##### Specific Objectives:

- Training enables the health functionaries to develop the skill of providing integrated management to neonates with essential care at birth, Nutrition through promotion of exclusive breast feeding, early identification of bacterial infections and diarrhoeal disease followed by appropriate treatment and early referral.
- Enabling the health care personnel in providing the integrated services to children from 2 months to 5 years for severe illnesses, diarrhoeal diseases, nutrition care through exclusive breast feeding, introduction of

complementary feeding at appropriate time, management of malnutrition followed by appropriate treatment, early referral and counseling of the mothers and family for appropriate care at home and seeking care at health facility whenever required.

- Enabling the health workers and ASHA in providing home care to newborns and sick children.
- Enabling the medical officers and staff nurses of 24x7 PHC's and CHC's in providing essential services to new borns and sick children at facilities.

**Outcome:** Promoting better neonatal care at facility at the time birth by trained man power and later on at home by mother and family members supported by specially trained ANM, ASHA and AWW will help in bringing down the morbidity and mortality among the neonates. This will further help us to bring down Infant mortality and thus child mortality.

## **200. Facility based IMNCI training ;**

Facility Based Integrated management of Neonatal and child hood Illness training will be imparted to Medical officers working at PHC,CHC and FRU's, so that they will be able to manage the neonates and young children more effectively in the absence of a paediatrician. From 2006 to 2009 MO's from 14 districts were trained and for the year 2010-11 MO's from remaining 15 districts are proposed to be trained so that all 29 districts will able to implement F IMNCI.

IMNCI is proposed for Staff Nurses of PHC/CHC and health and nutrition training of field health functionaries along with AWW



**IMNCI training Progress from 2006 to Dec 2009 (\* Raichur training was done by UNICEF between 2005 to 2006)**

District	MO			SN			ANM and LHV			AWW			district wise GRAND Total		
	target	Achievement	Balance	target	Achievement	Balance	target	Achievement	Balance	target	Achievement	Balance	target	Achievement	Balance
Raichur*	67	70	11	111	38	111	242	233	23	2021	1621	400	2927	1962	965
Bidar	145	57	88	112	52	60	361	289	72	1556	1556	0	2174	1954	220
Koppal	66	23	43	154	12	142	198	20	183	1276	0	1276	1694	55	1639
Gulbarga	250	55	220	300	189	111	445	447	-2	3300	2388	912	4295	3079	1216
Bellary	117	56	61	115	0	115	385	272	113	2073	711	1362	2690	1039	1651
Darwar	52	35	17	68	0	68	240	79	135	1194	1181	13	1554	1295	259
Haveri	126	17	109	81	51	30	372	329	6	1650	1362	288	2229	1759	470
Gadag	100	21	79	90	9	81	202	188	0	1002	1000	2	1394	1218	176
Belgaum	140	272	-132	127	0	127	611	0	516	4800	0	4800	5678	272	5406
Uttar kannada	102	44	58	130	0	130	393	32	354	1838	0	1838	2463	76	2387

Bijapur	72	52	20	117	82	35	357	55	302	1879	94	1809	2425	283	2142
Bagalkot	174	36	138	250	79	171	241	133	108	2146	70	2076	2811	318	2493
Chamrajanagara	113	41	72	150	23	127	251	222	29	1303	1024	279	1817	1310	507
Kodagu	65	40	25	65	0	65	212	236	-24	854	210	854	1196	486	710
<b>Category wise Grand Total</b>	<b>1589</b>	<b>819</b>	<b>809</b>	<b>1870</b>	<b>535</b>	<b>1373</b>	<b>4510</b>	<b>2535</b>	<b>1815</b>	<b>26892</b>	<b>11217</b>	<b>15909</b>	35347	15106	<b>20241</b>

**201. Strategies under Facility based new born care training :**

MO's and Staff nurses of the 24x7 PHC's and CHC's will be trained under this programme.

**202. Home based new born care:**

As per the state HMIS report till November 2009 the number institutional deliveries have increased to 30 to 40 % as compared to previous year, this phenomena is also seen in the low reforming 7 C category districts of Karnataka. Even with this increase in institutional deliveries, the hospital stay of the mother and newborns after delivery is ranging from 3 hrs to 48 hrs. Because of this large number of newborn babies and post natal mothers are at home from 1<sup>st</sup> day onwards and it is also observed that neonatal and post natal maternal morbidity and mortality is high during the 1<sup>st</sup> 7 days after delivery. In order to prevent this morbidity and mortality the family and mothers should be supported with health care providers who are trained in Home Based Newborn care are available round the clock in the same locality and she can follow the mother and baby at an specified interval and helps the family to take care of them.

ASHA and ANM's from 6 'C' category districts and 1 tribal district with high incidence of home delivery and infant deaths will be taken in the 1<sup>st</sup> phase as per the Gudchiroli model with locally needed modification. Extension of HBNCC also will be done in one to two taluks of 5 High Focused Districts who have high incidence underserved and un served population. In these areas HBNCC as per the GOI model will be under taken.

**203. Care of sick child and severe Malnutrition:**

MO's working at PHC, CHC and FRU's will be trained in taking care of sick child and severe malnutrition through F- IMNCVI programme. SOP's and protocols for management of sick child also will be developed. The lack paediatricians in the FRU's and CHC's will be bridged by trained MO's with these skills.

**204. Immunization training:**

Capacity building of MO's in immunization programme along with management and surveillance of AEFI is under taken as and when required.

**205. Strategies under Family Planning Programme trainings :****Specific Objectives:**

Pace of improvement in sterilization services has to be stepped up considerably in fulfilling unmet needs in limiting methods and achieving the goals of family welfare set by National population policy and NRHM.

Increasing the pool of service providers through training and certification of service providers is the critical inputs for the effective implementation of Fixed day approach.

- Up grading the skills and knowledge of the Obstetricians and Surgeons in conducting laproscopic tubectomy, counseling the clients and maintenance of quality and standard of operating procedures.
- Up grading the skills and knowledge of the MBBS doctors in providing minilap tubectomy services, no scalpel vasectomy services and IUCD services along with counseling of clients, provision of quality service at 24x7 PHC and CHC's.
- Up grading skills and knowledge of staff nurses and ANM/LHV's in providing the IUCD services along with counseling and follow up services.

**206. Out Come:**

Provision of quality service along with proper counseling and follow up services by the health care providers will increase the client satisfaction and thereby lesser rejection rate, more demand and acceptance and long sustenance of FP methods. This will in turn result in increase in use of spacing methods, increase in coverage

of unmet needs and there by increase in CPR and reduction of TFR to less than 2.08 by 2009-10.

**207. Strategies under FPP Training:**

Strategies planned as per the GOI guidelines keeping in mind the The activities proposed, responsible agency taking up the training and training guidelines

**207. Laproscopic training:**

Gynecologist or Surgeons along with staff nurse and OT attender is given this training for 12 working days as per the GOI guidelines. These Gynecologist and Surgeons are also oriented about quality assurance in standard procedures in male and female sterlization technique.

**209. Minilap Tubectomy training :**

MO's of 24x7 PHC's and CHC's along with staff nurses and OT attender is given this training for 12 working days as per the GOI guidelines.

**210. NSV training:**

It is proposed train MO's of 24x7 PHC's and CHC's in NSV for 6 days so as to provide NSV services to the clients whenever necessary. As the state do not have institution with good case load required for the training , it is proposed to train the doctors during special camps held for NSV or at neighboring state where the NSV services provided in good number.

**211. IUCD training:**

As per the GOI guidelines, an alternate method of IUCD insertion technique training is provided to MO, Staff Nurse, LHV and ANM with help of anatomical pelvic model provided.

## **212. Adolescent Reproductive Sexual Health:**

### **Specific Objective:**

- To enable the Medical Officers of PHC/ CHC and Health workers at community to address the special needs and concerns of Adolescent Boys and Girls and to design appropriate approaches.
- Training enables the health provider to acquire the needed knowledge about characteristics of adolescents, understand the needs of adolescents.
- MO's and other health workers will be equipped with skills and resources there by able to provide Adolescent Friendly Health Services through **Sneha Clinics** at PHC's and CHC's and through routine health services by ANM at Sub centre.

### **213. Out Come:**

By providing Friendly Integrated Holistic Health Services the needs of Adolescents will be met and the special focus on out of school, girls married before 18 years of age or newly married young couples , and adolescent in among high risk group will helps in improving basic health and life style of these group. Ultimately this will help in bringing down the early marriage, adolescent pregnancy, and there by IMR, MMR and TFR.

### **214. Strategies:**

ARSH services which has been introduced in 12 districts of Karnataka in the 1<sup>st</sup> phase will be extended to all the districts during 2010-11.

#### **Master trainers training:**

### **215. ARSH training to MO's :**

MO's from PHC and CHC will be trained at SIHFW and 4 HFWTC's for 3 days.

### **216. ARSH training to Health Workers:**

ANM/ HWM/LHV/ BHEO / counselors from ICTC and other supervisory staff will be trained for 3 days at DTC'c and HFWTC's.

**217. Sensitization workshop in ARSH:**

Anganawadi workers, ASHA and school teachers will be sensitized about ARSH services for one day at Taluk places by the taluk team.

**218. ASHA training:** Nearly 39000 ASHA's are identified in 29 districts. In the 1<sup>st</sup> phases 11200 ASHA's from 9 districts were trained by 2 NGO namely Narayana Hrudayalaya and Karuna Trust. During 2<sup>nd</sup> phase 16000 ASHA's from 11 districts and in the 3<sup>rd</sup> phase 12000 ASHA 's will be trained through District Training Centers. 39000 ASHA's will be trained and placed in the community by October 2010.

**219. AYUSH Doctors training:** as process of mainstreaming the AYUSH under NRHM, AYUSH medical officers working in PHC's will be trained for multi skill mainly: maternal health SBA, IMNCI, Immunization, Disease Control programmes and other national health programmes.

**220. Other National Health programmes;** Capacity building of the health personnel in other heath programmes also been done as per the national guidelines.

<u>Format TRG-A, Format for Underserved district (Basic information)</u>		NON NEGOTIABLE information	
	State Total	Underserved districts Total	% of the State Total
Total Number of district	29	11	
Total Population	52851000	20753266	

Total Number of Underserved District	11	22 taluks	
Total Population of all Underserved district	20753266	1649500	
Total Number of Medical Officer	2203	1000	
Total Number of Staff nurse / Male Nurse	4581	1980	
Total Number of ANM	8993	1100	
Total Number of LHV	1402	450	
Total Number of OBG	285	56	
Total Number of Anesthetic	158	35	
Total number of Pediatrician	190	37	

<b><u>Format TRG-B, Health Facility wise status in underserved districts</u></b>										<b>NON NEGOTIABLE information</b>	
Sl no	Name of district	Number of Health Facility				Number of Health Facility Functional as on 30 Nov 09-10 (cumulative total)			Number of Health Facility to be operationalize in proposed year 10-11		
		SC	PHC	CHC	TH working with as FRU	SC with SBA*	24X 7 PHC	FRU	SC with SBA*	24X 7 PHC and CHC **	FRU****
<b>High Focused Districts as per GOI</b>											
1	Bidar#	234	50	16	4	15	74	20	100	50	10
2	Bellary	272	70	7	6	0	79	10	100	200	13
3	Raichur#	196	52	4	5	7	51	0	100	30	20
4	Chamarajanagara	246	57	3	3	0	69	0	30	60	15

5	Chitrdurga	273	86	10	5	34	69	0	100	30	25
6	Davanagere	291	103	4	5	34	69	0	100	30	25
7	Kolar	201	60	2	4	0	93	0	50	46	20
<b>“C” category districts : #Bidar and Raichur also considered under “C” category.</b>											
8	Gulbarga	507	126	20	10	0	160	0	100	110	50
9	Koppal	183	45	8	3	20	75	25	100	20	10
10	Bijapur	285	64	8	4	0	84	0	100	50	20
11	Bagalkot	224	47	7	5	17	112	0	100	40	25
		<b>2912</b>	<b>760</b>	<b>89</b>	<b>54</b>	<b>127</b>	<b>935</b>	<b>55</b>	<b>980</b>	<b>666</b>	<b>233</b>

\* only the ANM's SC with building and conducting deliveries will be considered for training , \*\* 3 SN per 24x7 PHC, \*\*\* 5 SN per FRU will trained

<b><u>Format TRG-C, Training status and proposed training for underserved districts : 11 districts ; Bidar, Bellary, Raichur, Kolar, Davangere, Chitradurga, chamarajanagara, Bijapur, Bagalkot, Gulbarga, Koppal.</u></b>					NON NEGOTIABLE information						
<b>Trainings</b>	<b>Total Target for state (State total) (including existing staff+ proposed recruitment in 10-11)</b>	<b>For underserved District only</b>				<b>Development Partners / NGO partnership in trainings if any</b>	<b>Data Source for the training achievements (HMIS, State MIS, TNA or Survey etc)</b>	<b>Remarks</b>			
		<b>Total Target for these districts</b>	<b>Achievement in trainings updated till 31 Dec 09</b>	<b>Projected Training Load for the year 10-11</b>	<b>Number of Health Facility to be Operationalize with trainings in</b>						

SBA (MO)	2200	1000	0	750	493	13 medical colleges hospitals	HMIS	Due to delayed development of training manuals and guidelines by GOI trainin of MO was delayed
SBA (ANM)	4500	1400	127	980	980	identified 42 hospitals	HMIS	only the ANM's from Sub centre conducting deliveries will be taken for the training
SBA (SN)	4500	1479	935	899	493	identified 42 hospitals	HMIS	3 Staff nurses/24x7PHC and 5/FRU will be trained
IMNCI (MO)	2200	1000	389	611	760	Medical colleges and DTC, HFWTC	HMIS	
IMNCI (ANM/SN/LHV)	1432	4432	2884	1548	760	Medical colleges and DTC, HFWTC	HMIS	
IMNCI (ASHA)	39000	11000	0	3000	3000	Taluk level with the help of Taluk team		will be taken up in 2 taluks of these districts as per HBNCC module
IMNCI AWW	52000	11000	6000	2000	8000	Taluk level with the help of Taluk team	HMIS	will able to complete over 2 years

Name of trainings	Need of trainings (Give Health indicators, Survey results, Training Need assessments TNA )	Remarks
IMNCI	IMR of State, or district (if in few district only )	As per HMIS report infant deaths in these 7 C category districts and few taluks of remaining 5 district is high it is very essential training the all health functionaries of these districts to be trained in IMNCI and there by managing the neonates and children efectively
SBA	MMR, TNA for the training, Survey results	as the institutional deliveries is increased to nearly 80 to 85% and as majority of the deliveries are happening at 24x7 PHC's and, CHC's and FRU's in order to have the quality and safe delivery to happen at tehses facilities it is very essential training the SN, ANM and LHV's under SBA and the MO's also to be trained in SBA
EMOC	MMR, IMR related to non availability of the EMOC, Shortage of Specialists,	as the state is having only 50% of spaecilist post filled mainly OBG, Anesthesia and Paediatricians and as state need to functionalize 192 FRU's and 24 district hopsitals it is very essential training the MBBs doctrs in EMOC and needed emmergency obstetric services can be provided in these places

<i>Format TRG –E (with the intention of cumulative budget for trainings in different programs)</i>			
SI NO	Trainings under Program	Funds for trainings (only training funds to be given): in lakhs	Remark
1	RCH Part A	2190.13	RCH Part A Trainings are done through SIHFW with help of district and sub district level training facilities
2	RCH Part B		
	ASHA Trg	585	
3	Immunization MO	29	
4	IDSP	105.36	<b>Trainings under other disease control programmes are been conducted by the respective programmes at district and state level</b>
5	NVBDCP		
	Malaria	124.95	
	Filaria	7.2	
	Dengue andf Chicken Guinea	11.1	
	JE	3.91	
6	NLEP	17.4	
7	NPCB	13.75	
8	RNTCP	251.68	
9	NPPCD	24	
10	National Mental Health Programme	20	
11	NIDDCP	0	
<b>12</b>	<b>Total</b>	<b>3383.48</b>	

<b><i>Format TRG –F, for Training integration or clubbing of the various training</i></b>			
Integrated Training packages for Staff	Various Training proposed for the Health personnel	Integration of Trainings as per state needs	Remark
For ANM	IMNCI, SBA, IUD(6 day), Alt IUD (1 days), RTI/STI (3 days), ARSH Small duration neonatal care trainings (Neonatal Resuscitation, 5 days), Essential newborn trainings 2days) + Trainings under Disease control programs and others trainings	i.e. SBA+IMEP+IUD+RTI/STI or Minilap+ MTP +RTI/STD+IMEP	Mo's who are posted for DBA will undergo integration of various trg as shown
For MO	IMNCI, SBA, Alt IUD, RTI/STI, Neonatal care, Mini-Lap, Lap and NSV trainings	IMEP+ RTI/STI+ ARSH+ Alt Contraceptive update	IMEP+ RTI/STI+ ARSH+ Alt Contraceptive update
For SN	IMNCI, SBA, IUD, RTI/STI, Neonatal care trainings,	IMNCI, SBA, IUD, RTI/STI, Neonatal care trainings,	NIHFW has also proposed and suggested trainings integration to states

### **221. Integration of Training:**

As the Medical and Para Medical workers need to undergo multiple trainings of both short and long training and the man hour spent on training will be for more than 5 to 10 days. Hence it is planned to integrate few of the training so that the trainee need not be drawn multiple times for the training. Few of the integration is shown in the Form G.

Information regarding multiple training to health workers / Officials							
	Total Number of Staff	Long-term trainings (Duration more than one month) PDC, EMOC, LSAS & others		Short-term trainings (Duration less than one month) IMNCI, SBA, IUD etc.		Trained in both trainings (long and short term trainings)	Remarks
		Number of Trainings	Persons trained in these trainings (Cumulative of last three years or since inception of trainings )	Number of Trainings	Persons trained in these trainings (Cumulative of last three years or since inception of trainings )		
MOs	2200	PDC	140	IMNCI	800	250	Integration of the trainings will be done as required and as feasible as per the NIHFWS guidelines
		EmOC	40	ARSH	500		
		LSAS	71	IUD	466		
				SBA	0		
SN	4500	NIL	NIL	IMNCI	308		
				ARSH	0		
				IUD	900		
				SBA	1076		
ANM	9000	nil	nil	IMNCI	2514		
Others (please specify)				ARSH	0		
				IUD	1212		
				SBA	908		

**District wise prioritization of trainings and  
District Need Based Training**

**District wise number of functioning 24x7 PHC, FRU,  
Sub Centres**

	<b>FRU</b>	<b>24x7 PHC</b>	<b>Total</b>	<b>SC</b>
Bangalore U	4	21	25	185
Banagalore R	4	17	21	192
Ramanaga	4	14	18	240
Koalr	5	45	50	201
Chikkaballapur	6	19	25	184
Tumkur	9	87	96	477
Shimoga	6	20	26	307
Chitradurga	6	31	37	273
Davanagaere	6	31	37	291
Mysore	10	25	35	432
Chamarajanaga a	5	40	45	246
Mandya	7	32	39	375
Kodagu	5	10	15	188
Hassan	8	37	45	420
Chikkamagalur	7	28	35	334
D. Kannda	6	23	29	431
Udupi	8	23	31	293
Belagaum	11	74	85	539
Bijapur	5	42	47	285
Bagalkot	10	40	50	224
U. Kannda	10	30	40	120
Dharawar	5	29	34	179
Haveri	7	27	34	290
Gadag	5	20	25	174
Gulbarga	10	86	96	378
Bidar	5	34	39	234
Raichur	5	26	31	196
Koppal	5	28	33	183
Bellary	8	35	43	272
	<b>192</b>	<b>974</b>	<b>1166</b>	<b>8143</b>



**222. Monitoring and Evaluation of the training programmes:** Evaluation of the trainings are done in three phases and the some of the monitoring system is in built among the system of training in the form of pre test/post test, feed back from trainees and trainers, proficiency evaluation etc;,. It is proposed to take up external evaluation of training through calling EOI. Different checklist and monitoring mechanism developed with help of NIHFW, UNICEF and WHO is used for the process. On the place evaluation of the health worker 3 to 6 months after the training is also built in the system. Evaluation is been carried out internal as well external agencies to under stand the lacunae.

**223. Training cost :**

Training cost is calculated as per the GOI guidelines.

SINo	Item	Cost
1	Per diem to Trainees or participants	Guidelines awaited
2	Honorarium to resource persons To Guest resource persons In house faculty	@Rs.500 per session not more than 2 per day  @ Rs. 200/ session
3	Training materials	@Rs. 250/participant/day
4	Refreshment	@Rs. 250/participant/day
5	IOH- Institutional Over Heads	10% of 1+2+3+4
6	Travelling cost as per State rules	



Comprehensive Training Plan under NRHM for the year 2010-11 as per the State PIP (Rs. In lakhs)														
Sl No	Name of the training	Category to be trained	Total Training Load	Already trained	for the year 2010-11	Training venue	Duration	Batch size	Total Batches	Total to be trained	Cost per Batch	Total Cost	Time line	Remarks
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
A	Strengthening Training Institution											99.00	Apr to Sep	Detailed information given in detailed budget
	Development of training package												Apr to Sep	
1	Maternal Health Training													
1.1	Skilled Attendance at Birth / SBA											300.00		
1.1.1	SBA Training	TOT		253										
1.1.1	SBA Training	MO	1200 from 24/7PHC and CHC	0	750	13 identified Medical Colleges	10 days	10	75	750	190000	142.5	Apr to Mar	750 Mo are targeted to be trained under SBA-BEmOC for 2009-10, Monitoring of the training is taken up as per the guidelines provided by the GOI,

<b>1.1.2</b>	SBA Training	staff nurses	3600 from 24/7 PHC and CHC	3504	1500	42 identified centers	21 days	3	90	270	46000	41.4	Apr to Mar	
<b>1.1.3</b>	SBA Training	ANM	4400 from SC and 24x7 PHC/CHC	769	1200	42 identified centers	21 days	3	300	900	46000	184.00	Apr to Mar	
	SBA Training	AYUSH Doctors	300 AYUSH Doctors working in PHC	146	200	24 District hospitals	21 days	5	40	200	110000	44.00	Apr to Mar	
<b>1.2</b>	<b>EmOC Training</b>											<b>50.00</b>		
<b>1.1.1</b>	<b>center setting cost</b>												Apr to Sep	
<b>1.1.2</b>	Minitoring and others	from medical college											June/ July	

<b>1.1.3</b>	EmOC Training	MO	108 over 3 yrs	40	56	VVH, Cheluvamba hospital, KMC hospital and identified DH	16 wks	8	6	48	850000		April to March	
<b>1.3</b>	<b>Life saving Anaesthesia skills training</b>									0				
	Setting up of Life saving Anaesthesia skills Training Centres-JNMC Belgaum									0			June/ July	
	TOT for Anaesthesia skills traininge-									0			July/ August	
<b>1.3.1</b>	LSAS	MO	108	71	36	4 medical colleges and district hospital	18 wks	4	7	28	410000	28.7	Apr to March	
<b>1.4</b>	<b>11.3.4 MTP</b>									0				

	<b>Training</b>													
<b>1.4.1</b>	TOT in MTP using MVA	district trainers								0				
<b>1.4.2</b>	11.3.4.2 Training in MTP using MVA	MO	323	237	80	identified hospitals	12 days	2	16	32	24000	7.14	April to March	
<b>1.5</b>	<b>11.3.5 RTI/STI Training</b>											22.44		
	11.3.5.1 TOT for RTI/STI training	district trainers	87	87										KSASPS
	RTI/STI	MO from 24x7 PHC's	1200	1000	450	DTC/ HFWTC/ SIHFW	3 days	30	20	600	62000		April to Sep	
	RTI/STI	staff nurses from 24x7 PHC's	<b>3600</b>	<b>750 as on Nov 2009</b>	<b>1000</b>	DTC/ HFWTC/ SIHFW	<b>3days</b>	<b>30</b>	<b>10</b>	<b>300</b>	<b>40000</b>		April to Sep	
	RTI/STI	LT from 24x7 PHC's	<b>1200</b>	<b>400 as on Nov 2009</b>	<b>450</b>	SRL by KSAPS	<b>5 days</b>	<b>30</b>	<b>12</b>	<b>360</b>	<b>50000</b>		April to Sep	

	RTI/STI	ANM/ LHV's	11000											
1.7	11.4. IMEP Training	MO's of PHC/CHC										33.6		
1.7.2	11.4.3 IMEP training	MO	3200	nil	1200	DTC/ HFWTC	2 days	30	40	1200	62000		Apr to Mar	
	IMEP trg to	Seniour Staff Nurses	1200	nil	1200	DTC/HFWTC	2 days	30	17	510	50000			
2	<b>11.5 Child Health Training</b>													
2.1	<b>11.5.1 IMNCI Training ( in-service)</b>											<b>340.00</b>		
2.1.1	11.5.1.1 TOT on IMNCI	District team	150 from rest of 15 districts	222 in old 14 districts	150	SIHFW and Medical Colleges	11 days	30	5	150	300000		Apr to Jun	TOT is done for the districts team from rest of 15 districts in the state, district team is trained 10 per district.

2.1.2	Physician training in IMNCI	MO	1000	70	750	DTC/HFWTc with medical colleges	11 days	30	33	1000	250000	Jun to Mar	Spill over MO's from from previous 14 districts and new batches from rest of 15 district will be trained at district level.
2.1.3	Physician training in IMNCI	Staff Nurses	3000	308	1000	DTC/HFWTc with medical colleges	8 days	30	33	1000	160000	Jun to Mar	at district level
2.1.4	Health and Nutrition training in IMNCI	ANM/LHV	9150	2184	1000	Sub district level at Taluk hospitals and DTC	8 days	30	33	1000	160000	Jul-mar	at sub district level with help of TOT's
2.1.5	Health and Nutrition training in IMNCI	AWW	52000	9593	3000	DTC/HFWTC with medical colleges	8 days	30	73	2190	160000	Jun to Mar	at sub district level with help of TOT's
	IMNCI to AYUSH	AYUSH Doctors	600	100	300	DTC/HFWTC with medical colleges	8 days	30	10	300	200000	Jun to Mar	

2.2	Facility Based Newborn Care												106.9	
	<b>TOT in FBNC</b>	<b>District Team</b>	<b>290</b>	<b>nil</b>	<b>150</b>	<b>SIHFW and Medical College</b>	<b>5 days</b>	<b>30</b>	<b>5</b>	<b>150</b>	<b>200000</b>		<b>Apr to Jun</b>	
2.2.1	NICU trg to MO's	MO from DH	51	nil	36	6 Regional centre at Medical colleges	16 weeks	4 to 5	9	36	410000		Jun to Mar	
2.2.2	NICU Trg	Staff Nurses from DH	288	nil	204	6 Regional centre at Medical colleges	12 days	3	68	204	50000		Jun to Mar	
2.2.3	Navajath Shishu Suraksha Training	Staff Nurses from PHC/CHC	3600	nil	3600	DTC/HFWTC with help of district hospitals	3 days	20	180	3600	20000		Jun to Mar	
2.3	<b>11.5.3 Home Based Newborn Care / HBNC</b>											<b>405.15</b>		
2.3.1	TOT on HBNC	district team	300	20	262	Gudchiroli and district level	24 days	30	9	262	465000		Apr to Jun	for 16 Taluks of 7 C category districts and 1 tribal districts will be done

															as per the Gudchiroli model
2.3.2	Training in HBNC	ASHA	11200	22	3700	District and sub district level	15 days	30	123	3700	210000		Jun to Mar	3700 ASHA's from 16 Taluks of 7 C category districts and 1 tribal district	
	Training in HBNC	ASHA	6000	nil	3000	District and sub district level	6 days	30	100	3000	105000		Jun to Mar	3000 ASHA's will be trained from 10 Taluks as per GOI Model of 6 days	
2.4	Care of Sick Children and Severe Malnutrition														
3	<b>Family Planning Trainings</b>														
3.1	Laparoscopic sterilisation training (108)	Team comprising of Gynecologist/ surgeon with staff nurses and OT	300 teams	111 Teams	30 Teams ( 90 persons)	3 identified centers	12 days	3	30	90	42000	12.6	Apr to Mar	work plan is shown in this CTP	

		attender												
3.2	Minilap Training	Team comprising of 1 MO 1 S/N & 1 OT Attender	1200 teams	313 teams	60 teams (180 members)	12 identified centers	12 days	3	60	180	23000	13.8	Apr to Mar	work plan is shown in this CTP
3.3.	<b>Non-Scalpel Vasectomy (NSV) Training</b>	<b>MO</b>	300		300	identified NSV centers	6 days	2	150	300	12000	18.00		work plan is shown in this CTP
3.4	<b>IUD Insertion along with Contraceptive up dates</b>											160.5		

3.4.1	TOT in IUCD insertion	District team	290	290		SIHFW and DTC Belagaum	6 days							completed
3.4.2	IUCD insertion training	MO	1500	558	450	identified centers at districts through DTC/HFWTC's	6 days	3	160	480			Apr to Mar	
3.4.3	IUCD insertion training	staff nurses	1500	265	1100	identified centers at districts through DTC/HFWTC's	6 days	12	160	1920	57000		Apr to Mar	
3.4.4	IUCD insertion training	ANM/LHV	9145	1212	3000	DTC/ HFWTC	3 days	12	250	3000	25000		Apr to Mar	
4	<b>Adolescent Reproductive and Sexual Health</b>											119.63		
4.1	Master Trainers Training	State team	30	6	30	SIHFW	3 days	30	1	30	315000		Apr	
4.2	TOT in ARSH	District team	180	40	102	SIHFW	3 days	30	3	102	237000		Apr and May	
4.3	ARSH training	MO	1000	301	500	DTC/HFWTC	3 days	30	50	1500	90000		may to march	
4.4	ARSH training	ANM/LHV	1000	nil	1000	DTC/HFWTC	3 days	30	90	2700	58000		Jul-mar	

4.5	ARSH training	AWW	52000	nil	40000	DTC/HFWTC	2 days	40	1000	40000	8000		Jul-Mar	
5	<b>11.8 Programme Management Training</b>													
5.1	<b>Training of SPMSU staff</b>													
5.2	<b>Training of DPMSU / BPMU staff</b>		700	54		SIHFW/NIHFW	3 days					25.00		
6	<b>Other trainings</b>													
	<b>Grand Total</b>											<b>1743.00</b>		

**CHAPTER – 17**  
**EQUITY /GENDER - PC & PNDT**

**224. Current Scenario:**

The state of Karnataka is also affected by the phenomena of reduction in child sex ratio. However the situation is not as alarming as that of the situation in Punjab and Haryana. In spite of this fact the PC and PNDT Act is being implemented strictly throughout the state of Karnataka. The child sex ratio in Karnataka (district wise) is given below.

Sl. No.	District	1991	2001
1	Belagaum	955	921
2	Bijapur	956	928
3	Mandya	959	934
4	Gulbarga	959	938
5	Bagalkot	NA	940
6	Bidar	962	941
7	Bangalore ®	957	942
8	Bangalore (U)	950	943
9	Dharwad	952	943
10	Davangere	NA	946
11	Chitradurga	960	946
12	Uttar Kannada	949	946
13	Ballary	957	947
14	Tumkur	970	949
15	Gadag	NA	952
16	Dakshina Kannada	956	952
17	Koppal	NA	952
18	Shimoga	961	956
19	Haveri	NA	957
20	Hassan	967	958
21	Udupi	NA	958
22	Chikkamagalur	978	959
23	Kolar	971	959
24	Mysore	966	962
25	Raichur	965	964
26	Chamarajnagar	NA	964
27	Kodagu	957	977
<b>All India average</b>		<b>945</b>	<b>927</b>
<b>Karnataka average</b>		<b>960</b>	<b>946</b>

**225.** As seen from the figures given above, only in Belgaum District the child sex ratio is lesser than the national average. The child sex ratio is lesser than the Karnataka average in 13 Districts of Karnataka. In Kodagu district of Karnataka, the child sex ratio has actually increased by 20 points.

**Activities:**

**226.** The public at large is still unaware of the provisions of PC & PNDT Act and also regarding the ban of female feticide. It is necessary to reach the public through the electronic and print media, hence adequate provisions are made in the PIP in this regard. Apart from electronic and print media, it is also proposed to conduct a state level workshop and several district level workshops. Suitable provisions are also made in the PIP for carrying out these activities.

**227.** It is proposed to conduct State level Workshop for Health Professionals to create awareness of the hazards of Sex ratio and at the District level for Health Staff as TOT to carry on the Programme to the Taluk level and Hobli level.

**228.** It is proposed to conduct Workshops at Taluk level four per year at the rate of ten thousand rupees per event involving the Health staff, PRI's members, NGO's and Media representatives.

**229.** It is proposed to carry out the above strategies with the aid of Audio-Visual media and print media and Electronic media along with the integrated work with NG

**Budget Rs.187.50 lakhs**

**CHAPTER-18**  
**PPP MNGO SCHEME**

**Introduction:**

**230.**Department of Family Welfare in the Ninth Five Year plan(1997to2002) introduced the Mother NGO scheme under the reproductive and child Health Program. Since then MNGOs are giving Services to the Community where gaps are observed in RCH case i.e.: unserved and underserved area. Schemes like Yashasawini, Telemedicine, Contracting out of Mobile Health units, training of ASHAS are some of the joint ventures that are already under implementation in the State under PPP basis.

**OBJECTIVE:**

**231.**The broad objectives of the intervention are to address the gaps in Information, Building capacity and issues at the District/field level/Advocacy and awareness generation.

**STRATEGIES:**

**232.**Strategic interventions are demand generation for quality Services, for Maternal and child Health Care, family planning, Adolescent reproductive Health and prevention and management of RTI.

**233.ACTIVITIES:**

- Designing communication plan / activities for Men/Women/Adolescent Girls and Boys.
- Health Education / Training for Women's group.
- Mobilizing eligible couples , individual men and women to participate in FP camp and RCH camp.
- Improve the quality of ANC, registration, tracking and services.
- Immunization tracking
- Spacing of births in all women in reproductive age group.
- Motivate for institutional deliveries.
- Community action for safe mother and child services.  
Institutional delivery by trained nurses.
- 48 hours stay in the Hospital after delivery.
- Breast feeding within half hour after birth.
- Reduce the Maternal mortality rate.
- Reduce the infant mortality rate (Annexure)

## CHAPTER-19

### VILLAGE HEALTH AND NUTRITION DAY

#### OBJECTIVE:

234. The Objective of this program is to provide antenatal services, post natal counseling, immunization, nutritional consulting all ANCs, PNCs and children.

#### STRATEGIES :

235. The State has changed its strategy to organize VHND at Sub centres rather than at every village in order to strengthen the programme yielding better results. Hence forth it is proposed to have every month one programmes per Sub center on 3rd Saturday.

#### 236. ACTIVITIES UNDER TAKEN ON VHND:

- ANC registration, tracking and services
- FP motivation for adopting for small family norm – permanent and temporary method (CC & OP distribution).
- IFA tablet distribution, actual consumption monitoring among both pregnant women and children,
- Weighing and growth monitoring  
Immunization – tracking of missed children

237. Funds for VHND are being utilized from untied Funds of Sub Center @ Rs. 50/- per programme.

#### Community Health Day:

##### Objectives:

- To showcase health care services available in the PHCs
- Improve community participation to enhance their health seeking behavior
- Enhance Community ownership
- Monitoring by state nodal officers

##### Strategies:

- To be organized once in 6 months at every PHC in the state.
- Funds upto Rs. 3000/- to be spent from PHC untied funds

## **CHAPTER-20**

### **Community Monitoring**

#### **Goal :**

**238.**Community Monitoring is an important concept under NRHM where in the community takes an important role in the functioning and monitoring health facilities and owns up the health facility.

#### **Objectives :**

**239.**So this end the capabilities of the community organization at the peripheral level as village health sanitation committee, Arogya Raksha Samithi etc. are to be built.

#### **Strategies :**

**240.**Capacity building exercise of the members of the VHSCs and ARs will be taken from the year 2009-10 and will run during 2010-11 also.

**241.**A government order has been promulgated in February 2009, constituting planning and monitoring committees, at village, PHC, taluka and district levels. The GO also details this organization duties and responsibilities.

**242.**Community Monitoring is taken up at PPP model in 4 Districts. This will be taken up in few more districts during 2010-11.

**Budget 5.00 lakhs**

## **PART-B**

### **CHAPTER – 21 NRHM ADDITIONALITIES**

- Community mobilization for health action : Provision of a need based, trained and supported village Accredited Social Health Activities (ASHA) who will create awareness on health and its determinants; mobilize the community for local health action and act as the interface with the health service delivery system.
- Capacity building of PRIs to own, control and manage public health services.
- Flexible/untied funds for local health action:Rs.10,000/25,000/50,000 at SC/PHC/CHC levels respectively.
- Support for ensuring that selected health facilities perform predetermined functions & to make facility functional or meet IPHS standards.
- Infrastructure development (civil works: undertake upgradation/additional facility separately for SCs/PHCs/CHCs/FRUs etc).

## CHAPTER – 22

### ASHA

#### **Accredited Social Health Activist:**

#### **243. Introduction:**

Government of India has launched National Rural Health Mission to address the needs of the rural population, especially the vulnerable section of the society. The Sub Center is the most peripheral level of contact with the community under the public health infrastructure. This caters to a population norm of 5,000, but is effectively serving a much larger population at the sub center level; the ANM is heavily over worked which impact the outreach services in the rural areas.

A new band of community functionaries named as Accredited Social Health Activist (ASHA) is proposed to fill this void. ASHA will be the first port of call for any health related demands of village people in general and deprived section of the population especially women and children in particular who find it difficult access health services.

#### **244. Objectives:**

- The main role of ASHA is act like a bridge between ANM & Public
- The main aim is to reduction of IMR & MMR
- The ASHA works with in 1000 population she take care small health problems
- Improving the institutional delivers
- Prevention and control of communicable and non- communicable diseases
- Promotion of health life styles

#### **245. Strategy:**

- ASHA primarily be a woman resident of the same village-preferably selected married widowed/ divorced.
- ASHA to act as a health resource person for maternal and child health matters
- ASHA empowered with knowledge and drug kit to delivery first contact healthcare
- ASHA will participate in public health programmes
- In First Phase Raichur was one of the selected district with a total of 1214 ASHA, currently 100% of them have been trained.

#### **246. Training of ASHA**

The training was started on February 2008 it was given to NGOs, Karunatrust & Narayana Hrudayalaya, Bangalore for 1<sup>st</sup> Phase covering 9 districts.

MOU was signed with these NGO's.

**247. Methodology:**

The training is participatory in nature with emphasis on having practical skills in communicating with people and providing basic health service and referral.

**1.TOT for ASHA Trainers,**

**248. Criteria for ASHA Trainers:**

Staff nurses are selected as a TOTs

A. ASHA Trainers shall be lady staff nurse with at least general nursing as qualification (However at least 20% of the ASHA Trainers will be ANMs from Government who shall also be selected by the second party, from among the list of ANM recommended by the DHO)

- a. ASHA trainers must be willing to stay at the venue for entire duration except for periods of leave that will be designated as per the training calendar.
- b. They must have communication and training skills and aptitude to work with rural women.
- c. Must be well versed in kannada.

**The ASHA will be trained in groups of 15 ASHAs for a period of 30 days, of which 21 days will be residential.**

**The training calendar will be as follows**

## ASHA Trainers calendar of work when they train ASHAs

1-21 day	Training center for training ASHAs
22 <sup>nd</sup>	Post training assessment & Review
23 <sup>th</sup> -27 <sup>th</sup>	Leave for 4 days
28 <sup>th</sup>	Prepare training plan for the next training batch/groups
29 <sup>th</sup> -30 <sup>th</sup>	Interaction with ASHA & ANMs of the previous batch/group at the PHCs

### 249. Infrastructure in Training Centers,

As TOT for ASHA trainers and ASHAs training is residential, following infrastructure and amenities are provided during the training.

1. All TOTs to ASHA trainers should be done centrally and training of ASHAs should be done at fixed place with identified trainers.
2. Training venue must have facility to accommodate 60-120 ASHA's at a time with following facility:
  - Toilet , bathrooms, and washing facility.
  - Good water supply and electricity.
  - Kitchen with dining hall.
  - Man power for Security,
  - Cook with assistants.
  - Cleaning staff to keep the premises clean.
  - Place for outdoor games and assembly.
3. As ASHAs have to be trained in small groups of 15, the training venue must have sufficient class rooms i.e. one for each group and two spare class rooms.
4. The class rooms must be provided with:
  - i. Big carpet for sitting purpose
  - ii. Black board
  - iii. training kit with flip chart of various health program , spare note books, pens, pencils, drawing sheets for activity, sketch pens, scissors, adhesive

tape, measuring tape, height and weight measuring scale, stapler, rubber bands, files, tags, bowls of different size for nutrition demonstration etc.,

5. Training centers must have 1 or 2 TV with DVD players and various CDs on health issues.
6. Each trainer should be provided with bag, pen, pencil, eraser, note book, identity card by the second party.
7. Training manuals shall be supplied by the second party.

A district level committee headed by DHO will constantly monitor the training programme .

SIHFW is responsible for over all ASHA training.

### **250. Activities:**

ASHA's can provide a variety of services to community like treatment minor ailments, service for women registering pregnant, counseling for family planning services, Child health, household survey, reporting maternal Deaths etc.,

Before going to field they under go training in all preventive healthcare aspects of pregnancy etc. it is the 30-day's training.

Total Three Phase Training conducted in Karnataka,

No. of ASHAs planned to be trained

FIRST PHASE-----11205.

SECOND PHASE-----15000,

THIRD PHASE-----12000, Targets are given as for Rural Population.

### **251. Incentives for ASHA:**

The **ASHA** will not be paid any fixed salary or honorarium per month. Instead, they will be paid **incentive** amounts mainly for specific events of utilization of maternal and child healthcare services within her village population by the S/C S/T and BPL families.

The payment of incentives to **ASHA** are as follows:

<b>SL No</b>	<b>Programme</b>	<b>Rs.</b>
1	Providing IUD services	<b>50</b>
2	Reporting infant Deaths	<b>100</b>
3	6 times post-natal visits	<b>50</b>
4	Getting child fully Immunized	<b>100</b>
5	Reporting of AEFI	<b>100</b>
6	Identifying low Birth weight Infants & Educating the Family about their	<b>25</b>
7	Weighing the home delivered infants	<b>25</b>
8	For Accompanying ANC's & Staying through out with them, for	<b>600</b>
9	Reporting Maternal Death	<b>500</b>
10	For Reporting and Registering RTI /STI cases to Institution	<b>10/per case</b>
11	Reporting Infant Death	<b>50</b>
12	Mobilizing the Children for Immunization	<b>100</b>
13	For Motivating NSV	<b>200</b>
14	For Motivating for Family Planning Operation	<b>150</b>
15	To participate in Pulse Polio Programme	<b>75</b>
16	To providing Dots till cure in RNTCP	<b>25250</b>
17	To participate in National Programmes viz. Malaria, Filariasis,	<b>100</b>
18	For taking Peripheral smear for all fever cases	<b>5 per case</b>
19	For identifying Leprosy Case	<b>100 per</b>
20	For Providing full treatment from PHC for leprosy MB	<b>400</b>
21	To Participate in Communicable Disease	<b>100</b>
22	For Motivating Community to Construct public toilets	<b>50</b>
23	For Identifying severe cases of epilepsy and taking them for treatment	<b>100</b>

<p>1. Finalize ASHA training programme</p> <p>2. Procurements of kits to ASHAs</p>	<p>a) 39195ASHA were identified in the year 2007 to 09.</p> <p>b) Trained for 21,000 ASHAs.up to Nov 2009,</p> <p>c)Alredy procured ASHA drug kits, 1500P ASHA Bags are procured.</p> <p>d) Performance related incentives to ASHA</p> <p>e) maintenance of VHSC accounts, committee meetings and the expenditure of VHSC amounts as per the guidelines</p> <p>f)Payment of ASHAs Incentives bye Bank transfer is planned this year.</p>	<p>Identification of ASHA Through VHSC comettes Grama shaba are given for certificates. Training cost of Rs.6250 per ASHA for 39195 ASHAs ASHA Drug kits @Rs 600 provided Incentives for ASHA are fixed 23 Items, ASHAs getting more in North Districts approximately Rs 2000 are calculated and South Districts approximately Rs 1500 are calculated.</p>	<p>--Creating awareness about the availability of the rural services scheme under NRHM and RCH and other related activities.</p> <p>--Encouraging institutional Deliveries</p> <p>--Providing and supporting all health activities in the fields such as RCH, FW, Immunization services, DOTs provider, identifying communicable and non-communicable diseases etc...</p> <p>--Creating awareness regarding VHSC, good drinking water facility and individual family toilet facility</p>	<p>--No of ANCs registered</p> <p>--No of JSY, Prasuti araike registered</p> <p>--No of children to be fully immunized</p> <p>--No of ANCs to be accompanied for institutional deliveries</p> <p>---No of beneficiaries promoted and accompanied for NSV and mini lap camps</p> <p>--services provided as DOT worker</p> <p>-- information shared regarding communicable, non communicable, complicated non relevant diseases of their region with the district</p> <p>-- good sanitation and drinking water facility improves the village health index</p>
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## CHAPTER - 23

### ANM Training Centers

**252.** New ANM Training Centers: The newly started all nine new ANM Training Centers have started functioning, since 01.08.08. The construction of new buildings for these nine training Centers is under progress. The other infrastructure needed to strengthen the nine centers to be attained by making necessary budgetary provision during 2010 – 11 also. The requirement of budget under the components is as under:

a)	Students of new 9 ANMTCs @ 1200/- per month <u>June 2009 Batch</u> For the period of April 2010 to November 2010	Stipend to ANM
	a1) Rs.1200 x 600 x 9 x 8 m <u>June 2010 Batch</u> (From June 2010 to March 2011)	129.92
	Rent for Building	
	a) For the period of April 2010 to March 2011 50000 x 9 x 12	105.53
	b) Payment of Salary to Contractual Staff Driver - 9 x 6131 x 12 = 6.62 DEO - 9 x 9131 x 12 = 9.86 Cook - 1 x 6905 x 12 x 9 = 7.46 Group D - 3 x 6905 x 12 x 9 = 22.37	
	c) Contingencies (2 Lakhs x 9) Payment of Telephone Bills, Ele Bills, Etc Office Expenses Honorarium to guest lecturers Affiliation Charges to INC & KNC Journals, Magazines	

### II. Old ANMTC

To continue to assist them with untied funds @ 1Lakh x 19	19.00
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### JANANI SURAKSHA VAHINI

**253.** This is an innovative scheme implemented by the Government of Karnataka wherein mobility support extended to needy pregnant mothers especially Emoc cases to reach the FRUs and if needed to transport to higher centres.

**254.** The objective is to reduce the maternal mortality by bringing pregnant mothers to FRUs for institutional deliveries. Further, new born is to be taken care of to prevent neo

natal/infant mortality and also needy neo natal cases to be shifted to NICUs either at district hospitals or at teaching hospitals. Under this scheme, each FRU is provided with an ambulance to have two drivers on contractual basis in addition to existing one so that round the clock services of JSV are made available. The drivers are provided with mobile phones on call to cater to the needy pregnant mothers and their new born babies.

### **AROGYA KAVACHA-(108)-Ambulances**

**255.** Another innovative pride life saving scheme of the Government of Karnataka implemented since August, 2008 is the Arogya Kavacha (108 ambulance) under PPP with EMRI agencies, Secunderabad. The scheme envisages in deploying well equipped ambulances with instruments and gadgets along with well trained paramedical staff to provide medical aid during the golden hour to accident victims, snake victims, heart ailments, pregnant mothers, and so on at the spots before being shifted to nearby hospitals.



**256.** Altogether 517 ambulances will be made available for the above services all over the state. They are deployed at strategic locations in such a way that any needy can call toll free telephone number “108” and the ambulance reaches the spot within 20 minutes in rural areas and 14 minutes in urban areas. The total estimated cost is 221 crores financed by state government under budgetary provision of Rs 10 crores under the 12<sup>th</sup> Finance Commission of Rs 112 crores. The remaining is contributed under NRHM. **The NRHM contribution for operation expenses of 517 (108 Ambulance) is Rs. 45 Crores.**

### **Mobile Medical Unit:**

**257.** The Mobile Medical Unit through mobile clinics is providing primary health care services throughout the year. Under centrally sponsored tribal welfare schemes both for state and NGO sector mobile medical and health clinics functioning in the state rendering primary health care for tribal areas and in areas inhabited by at least 40% tribal populations. This has increased the accessibility to health services of deprived population groups improves. The mobile health clinics have been outsourced to private organizations like reputed health care firms and NGOs. Each clinic will cover an area depending on the terrain and will have service points in strategic villages.

**258.Objectives:**

1. To provide quality primary health care services including referral services.
2. To contribute to the achievement of improvements in IMR, MMR and CMR and other health MDG goals in the area by reducing the infant and maternal mortality and communicable diseases like malaria, TB, AIDS, pneumonia, diarrhoea and dysentery.
3. To encourage the private sector in providing qualified essential health care to rural communities with the purpose to establish sustainable services in such communities.

**Total budget for Mobile Medical Units Rs. 450/- Lakhs**

**Citizen Help Desk:**

**259.**The urban poor encounter the problems like lack of awareness about the services provided, drugs and treatment provided free of cost. Long waiting time to get treatment, poor grievance redress system, lacks of awareness and about how to lodge complaints etc. To address these issues Citizen Help Desk have been setup through NGOs in govt. hospitals for more transparency and accountability in service provider. This has resulted in increased utilization of essential Health Services, particularly in underserved areas and among vulnerable groups so as to accelerate achievement of the health related Millennium Development Goals.

**260.Objectives:**

1. To empower the public with information about services available in the hospital.
2. Enhance the efficiency of the service providing staff, by counseling, confidence building and redressing their grievances.
3. Establish a link between service providers and users.
4. Guide the users of the health facilities available in Government.
5. Be the nodal point to receive grievances/suggestions and communicate it to the health staff or his higher ups for redressal.

**Total budget for Citizen Help Desk Rs. 168/- Lakhs**

**THE STATE HEALTH STSTEMS RESOURCE CENTER**

**261.**Today the NRHM State Health Systems Resource Center which is sanctioned has started functioning.

**BUDGET Rs.100/- lakhs**

## Part-C

### CHAPTER-24

#### IMMUNISATION

**Table-1**

**262. Current Status & Goals**

Sl. No.	Goals and its Indicators	Indicator Type	Current status	Projected			
				2008-09	2009-10	2010-11	2011-12
1	Immunization	HI	76.7 (DLHS-3)	80%	90%	95%	100%

- a. Achieving 95% FULL IMMUNISATION, 95% Pregnant women covered for TT as for state goals
  - b. Reliable cold chain system for storage and transportation of vaccine,
  - c. Quality of services,
  - d. Biomedical waste disposal,
  - e. Training of Health Care Provider,
  - f. Effective monitoring and evaluation of the programme.
- ❖ Immunization is one of the most cost effective public health interventions to reduce mortality and morbidity due to vaccine preventable diseases
  - ❖ EPI mainly focused on Diphtheria, Tetanus, Pertussis, Polio, Measles and childhood tuberculosis.
  - ❖ Hepatitis-B as a pilot programme started in 2002 four Districts,
  - ❖ Hepatitis-B extended to all district in the state in 2008-09
  - ❖ JE vaccine as a mass immunization programme implemented Bellary, Kolar, Chickballpur, Raichur, Mandya, Koppal, Bijapur & Dharwad,
  - ❖ JE vaccine is included in UIP after mass immunization programme in selected districts.
  - ❖ According to DLHS III Survey shows 2007-08 fully immunization is 76.7% BCG 96.9% DPT 84.8%, POLIO 90.3%, MEASLES 90.3%, & TT(PW) 86.9%,
  - ❖ The coverage report of Karnataka for 2009-10 (up to Nov09) is BCG 68%, DPT III 66 %, OPV III 66% TT (PW) 63 %, measles 63% & Hep-B 60 %
  - ❖ Financial support is provided through NRHM for strengthening of RI program in the State.

**Table-2****263. Situation analysis of the State Immunization Program****A. Basic information of the State/related to Immunization**

S. No	Beneficiaries	Target in Lakhs		
		2008-09	2009-10	2010-11
1	Pregnant women	11.84	12.45	12.45
2	0 to 1 yr infants	10.82	10.68	10.68
3	1-2 yr	10.21	10.42	10.54
4	2-5 yr	63.10	63.25	63.48
5	5 yr	72.5	73.01	73.01
6	10 yr	16.01	16.20	16.37
7	16 yr	13.01	13.14	13.29

**Table-3**

In Lakhs

S.No	Routine Immunization Sessions	2008-09	2009-10	2010-11
1	Session planned in Urban Areas	0.30	0.15	0.20
2	Session planned in Rural Areas	2.65	2.81	2.81
3	Total Sessions planned	2.95	2.97	2.97
4	Total Sessions Held	2.45	2.10	2.10
5	No. of session with hired vaccinators*	2.45	2.64	2.64
6	No. of hired vaccinators*	0.24	0.15	0.20

*\* No of sessions and vaccinators hired in 2008-09, 09-10 and planned for 2010-11*

**Table-4**

Table showing trend of IMR over a period of 5 years

S.No	Year	IMR of the State
1	2004	49(SRS2004)
2	2005	50(SRS2005)
3	2006	48(SRS2006)
4	2007	47(SRS2007)
5	2008	45(SRS2008)

**Table-5**

**B. Existing Support to the States**

Sl No	Item	Stock (functional) as on 31st Dec'09	Requirement			Remarks
			2009-10	2010-11	2011-12	
<b>1</b>	<b>Cold Chain Equipments-</b>					estimate for 2010-11&2011-12 has been projected if the requirement during 09-10 is not met.
a)	WIC	8	0	0	0	
b)	WIF	2	0	0	0	
c)	ILR	2263	768	768	768	
d)	DF	1857	905	905	905	
e)	Cold Boxes	3025	984	984	984	
f)	Vaccine Carrier	57000	11060	11060	11060	
g)	Ice Pack	2.5 lakh	0.82lakh	0.82lakh	0.82lakh	
h)	Vaccine Van	6	05	05		

<b>2</b>	<b>Vaccine stock and requirement (including 25% wastage and 25% buffer) in lakh doses</b>				<b>0.5</b>	
a)	TT	<b>13.0</b>	<b>86.3</b>	<b>86.8</b>		
b)	BCG	<b>5.00</b>	<b>31.6</b>	<b>31.6</b>		
c)	OPV	<b>1.90</b>	<b>73.2</b>	<b>73.4</b>		
d)	DPT*	<b>14.00</b>	<b>88.5</b>	<b>88.98</b>		
e)	Measles	<b>6.00</b>	<b>17.5</b>	<b>17.53</b>		
f)	Hep B	<b>0</b>	<b>70.0</b>	<b>70.12</b>		
g)	JE (Routine)	<b>0</b>	<b>2.82</b>	<b>2.82</b>		

<b>3</b>	<b>Syringes including wastage of 10% and 25 % buffer in lakh</b>					
a)	0.1 ml	6.31	12.32	12.34		
b)	0.5 ml	18.42	197.0	197.00		
c)	5ml	2.73	7.64	7.64		
*Note: DPT is to be given instead of DT at 5 yrs once the current stock of DT Vaccine is exhausted						



S. No	Name of District	Yearly Target 2008-09		Yearly Target 2009-10		BCG Coverage (in Numbers)		OPV - 1st Dose Coverage (in Numbers)		OPV - 3rd Dose Coverage (in Numbers)		DPT - 1st Dose Coverage (in Numbers)		DPT - 3rd Dose Coverage (in Numbers)	
		Infants	PW	Infants	PW	2008-09	2009-10*	2008-09	2009-10*	2008-09	2009-10*	2008-09	2009-10*	2008-09	2009-10*
1	Bangalore Urban	51136	56227	35419	41299	55880	31489	56748	32194	60264	34336	56748	32194	60264	34336
2	Bangalore Rural	57740	56540	65321	51768	44871	51768	35167	47260	36446	51678	34026	47260	36446	38224
3	Chithradurga	32034	35402	28681	33440	29032	17978	28825	17074	30476	17969	28825	17074	30476	17969
4	Davanagere	36119	39032	33181	38685	36016	20437	35440	19854	36333	20787	35440	19854	36333	20787
5	Kolar	22779	25028	35625	41535	22202	15328	21939	14805	22320	14954	21939	14805	22320	14954
6	Shimoga	0	0	27800	30440	31966	12660	28967	12444	31899	13218	28967	12444	31899	13218
7	Tumkur	32034	35402	28681	33440	29032	17978	28825	17074	30476	17969	21558	10757	21986	10994
8	Ramnagar	152011	16077	18109	21114	15841	8482	15499	8626	16912	9876	15499	9626	16912	9876
9	Chickbalapura	15901	27969	20252	23612	15901	20252	15901	20252	26259	17382	15901	20252	26259	17382
10	Belgaum	91342	98985	90914	105998	95656	50822	87058	64316	87029	63719	81092	64272	79541	63819
11	Bijapur	32034	35402	28681	33440	29032	17978	28825	17074	30476	17969	21558	17074	30476	17969
12	Bagalkot	38000	42000	46203	53869	42850	30380	40583	23410	40518	28597	39015	24265	37054	28847
13	Dharwad	57740	56540	65321	51768	44871	51768	35167	47260	36446	51678	34026	47260	36446	38224
14	Gadag	21940	23140	25334	29537	24600	11594	23370	10687	23305	10939	21558	10757	21986	10994
15	Haveri	14195	15641	14875	16384	14470	9860	14119	9873	14660	10275	14119	9862	16912	9876
16	U.Kannada	20434	22732	27583	32159	21177	13836	19656	13388	20027	13937	19558	13388	19565	13937
17	Bellary	51335	57740	56540	65321	51768	44871	51768	35167	47260	36446	51678	34026	47260	36446
18	Bidar	37521	41273	31230	36411	35900	22777	36853	20948	36553	20948	36853	20124	36553	23918
19	Gulbarga	89067	97038	92546	102546	92382	48854	85271	50762	85430	49966	85430	50762	85430	50762
20	Koppal	27124	29378	28312	33994	28928	21160	25783	19980	26782	19921	25783	19980	26782	19921
21	Raichur	32034	35402	28681	33440	29032	17978	28825	20252	26259	17382	15901	20252	26259	17382
22	Chickamagalore	17010	18344	17677	20610	17287	8919	0	0	18228	0	0	0	18228	10080
23	D.Kannada	22779	25028	35625	41535	22202	15328	21939	14805	22320	14954	21939	14805	22320	14954
24	Udupi	14195	15641	14875	16384	14470	9860	14119	9873	14660	10275	14119	9873	14660	10275
25	Hassan	27518	30262	28073	32730	26602	16207	24261	15626	25579	16929	24261	15626	25579	16929
26	Kodagu	23140	25334	29537	24600	11594	23370	10687	23305	10939	21558	10757	21986	10994	11169
27	Mandya	25019	27278	25802	30083	25551	16315	23473	14060	25425	15750	23473	13640	25425	15750
28	Mysore						68000		25800						
29	Chamarajanagar	14867	16519	14770	16750	14336	9020	14330	8793	14620	9256	14330	8793	14620	9256
	Total	905712	869693	860667	968523	823165	643124	752772	573158	792997	564424	713727	537971	774081	534004

S. No	Name of District	Yearly Target 2008-09		Yearly Target 2009-10		Hep B - 1st Dose Coverage		Hep B - 3rd Dose Coverage (Wherever applicable)		Measles Coverage		TT2+Booster Coverage		JE-routine (Wherever applicable)		Vit A- 1st Dose Coverage	
		Infants	PW	Infants	PW	2008-09	2009-10*	2008-09	2009-10*	2008-09	2009-10*	2008-09	2009-10*	2008-09	2009-10*	2008-09	2009-10*
1	Bangalore Urban	51136	56227	35419	41299	53497	31813	60264	34003	56875	32820	59333	37284	-	-	56875	32820
2	Bangalore Rural	57740	56540	65321	51768	30194	20262	12161	19317	37826	27017	2669	1267	0	0	35278	22659
3	Chithradurga	32034	35402	28681	33440	25761	17074	23262	17969	28754	16597	33634	19620	0	0	28754	16597
4	Davanagere	36119	39032	33181	38685	25222	18886	19978	18371	34516	19569	38962	22458	0	0	34516	19569
5	Kolar	22779	25028	35625	41535	22816	13714	16912	9876	15659	8692	17264	10002	0	0	15659	8692
6	Shimoga	0	0	27800	30440	29144	12466	31736	13160	31555	12622	31650	13981	0	0	31555	12622
7	Tumkur	32034	35402	28681	33440	11169	10013	7797	10191	23147	10611	26357	11972	0	0	23147	
8	Ramnagar	152011	16077	18109	21114	14339	9500	16912	9876	15659	8692	17264	10002	0	0	15659	8692
9	Chickbalapura	15901	27969	20252	23612	15901	20252	26259	17382	24243	15164	26125	17447	441	8573	24243	15164
10	Belgaum	91342	98985	90914	105998	49337	49237	35979	44893	88683		88700	66559	0		69524	73081
11	Bijapur	32034	35402	28681	33440	25761	17074	23262	17969	28754	16597	33634	19620	0	0	28754	16597
12	Bagalkot	38000	42000	46203	53869	20885	20262	12161	18317	37826	27017	41669	267	0	0	35278	22859
13	Dharwad	57740	56540	65321	51768	30194	23826	25299	17405	33585	22800	40811	22897	0	0	33585	22800
14	Gadag	21940	23140	25334	29537	11169	10013	7797	10191	23147	10611	26357	11972	0	0	23147	10419
15	Haveri	14195	15641	14875	16384	14339	8626	16912	9876	15659	8692	17264	10002	0	0	15659	8692
16	U.Kannada	20434	22732	27583	32159	17985	12504	18946	13028	19207	13688	20939	14651	0	0	19207	17005
17	Bellary	51335	57740	56540	65321	38224	30194	23826	25299	47548	33072	52311	37390	26280	16339	47548	29151
18	Bidar	37521	41273	31230	36411	16321	18688	16172	17405	33585	22800	40811	22897	0	0	33585	22800
19	Gulbarga	89067	97038	92546	102546	61936	44208	42630	40909	79875	41443	86358	46583			79875	41443
20	Koppal	27124	29378	28312	33994	-	15890		13097	27676	18875	31175	20988		7666	27676	18875
21	Raichur	32034	35402	28681	33440	15901	20262	12161	18317	37826	27017	41669	267	0	0	35278	22859
22	Chickamagalore	17010	18344	17677	20610		8398		9170	16469	9102	17888	10684			16469	9102
23	D.Kannada	22779	25028	35625	41535	22816	13714	20661	14549	22059	143609	23653	16282	0	0	22059	14609
24	Udupi	14195	15641	14875	16384	13477	9112	10154	9546	14103	9721	15359	104984	0	0	14103	10494
25	Hassan	27518	30262	28073	32730	-	10875	-	13000	25165	15748	27362	17968	-	-	-	15748
26	Kodagu	23140	25334	29537	24600	10013	7797	10191	23147	10611	8592	15264	10052	0	0	15669	9692
27	Mandya	25019	27278	25802	30083	10411	14594	21042	13572	24172	14691	27812	18784	816	10701	24172	14691
28	Mysore												19773				
29	Chamarajanagar	14867	16519	14770	16750	8750	8029	8150	8811	13966	8754	17268	10440	-	-	13966	8754
	Total	905712	869693	860667	968523	471211	410758	419721	412553	738231	399513	779726	519397	27537	43279	691321	450386

**Table-6**

**Additional Support required by the State**

Service Delivery: -	Norms*	Expenditure & Achievement									Remarks
		2005-06	2006-07	2007-08	2008-09		2009-10 (till Dec'09)		2010-11		
		Expenditure	Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
<b>Mobility support for supervision</b>  Supervisory visits by state and district level officers for monitoring and supervision of RI	@Rs.50,000 per District for district level officers (this includes POL and maintenance) per year  By state level officers @ Rs.100,000 /year		6.63	14.65	9.04	No of sessions Supervised	6,07	No of sessions Supervised	14.50	No of sessions Supervised	
						1392		928		2088	
						No of districts visited for RI review		No of districts visited for RI review		No of districts visited for RI review	state nodal officers visiting every month 348
						58		32		58	
<b>Cold Chain maintenance</b>	@ Rs 500 per PHC/CHC per year District Rs 10,000 per year	11.21	36.50	115.24	39.18	% Funds used	25.9	% Funds used	25.94	% Funds used	
						75		100			

Service Delivery: -	Norms*	Expenditure & Achievement								Remarks	
		2005-06	2006-07	2007-08	2008-09		2009-10 (till Dec'09)		2010-11		
		Expenditure	Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Funds requirement		Target
<b>Focus on slum &amp; underserved areas in urban areas:</b>	Hiring an ANM @Rs.300/session for four sessions/month/slum of 10000 population and Rs.200/- per month as contingency per slum of i.e. total expense of Rs. 1400/- per month per slum of 10000 population.		<b>111.84</b>	<b>91.18</b>	<b>57.22</b>	No of sessions with hired vaccinators	<b>30.49</b>	No of sessions with hired vaccinators	<b>63.46</b>	No of sessions with hired vaccinators	
						<b>0.24</b>		<b>0.15</b>		<b>0.20</b>	
<b>Mobilization of children through ASHA/ mobilizers</b>	@ Rs 150/session (for all states/UT.s)		<b>118.03</b>	<b>63.09</b>	<b>202.75</b>	No. of sessions with ASHA	<b>93.79</b>	No. of sessions with ASHA	<b>281.47</b>	No. of sessions with ASHA	
						<b>2.65</b>		<b>1.87</b>		<b>2.81</b>	
<b>Alternative Vaccine Delivery:</b>	Geographically hard to reach areas (eg. Session site>30 kms from vaccine delivery point, river crossing etc.) @ Rs 100 per RI session		<b>69.09</b>	<b>60.83</b>	<b>118.98</b>	No of sessions with AVD	<b>44.37</b>	No of sessions with AVD	<b>132.24</b>	No of sessions with AVD	

**Table-7**

Service Delivery: -	Norms*	Expenditure & Achievement									Remarks
		2005-06	2006-07	2007-08	2008-09		2009-10 (till Dec'09)		2010-11		
		Expenditure	Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
	NE States and Hilly terrains @100 per RI session										
	For RI session in other areas @ Rs.50 per session.					2.45		1.76			2.64
<b>Support for Computer Assistant for RI reporting</b> (with annual increment of 10% w.e.f. from 2010-11)	State @Rs 12,000-15,000 p.m.										
	Districts @ Rs 8000-10,000 p.m		19.09	20.40	19.74	No of C.A. in position	9.14	No of C.A. in position	34.80		No of C.A. in position
						28		28			30
<b>Printing and dissemination</b> of immunization cards, tally sheets, monitoring forms, etc.	@ Rs 5 per beneficiary			15.37	1.66	55	4.88	55	49.00	49	

**Table-8**

Service Delivery: -	Norms*	Expenditure & Achievement									Remarks
		2005-06	2006-07	2007-08	2008-09		2009-10 (till Dec'09)		2010-11		
		Expenditure	Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
<b>Review Meetings</b>	Support for Quarterly State level Review Meetings of district officers @ Rs 1250/participant/day for 3 persons (CMO/DIO/Dist Cold Chain Officer)				9.36	No of meetings held	2.5	No of meetings held	5.00	No of meetings held	
						4		3		4	
	Quarterly Review & feedback meeting for exclusive for RI at district level with one Block MO.s, ICDS CDPO and other stakeholders@ Rs 100/- per participant for meeting expenses (lunch, organizational expenses)										

Table-9

Service Delivery: -	Norms*	Expenditure & Achievement								Remarks	
		2005-06	2006-07	2007-08	2008-09		2009-10 (till Dec'09)		2010-11		
		Expenditure	Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Funds requirement		Target
	Quarterly review meeting exclusive for RI at Block level @Rs 50/-pp as honorarium for ASHAs (travel) and Rs 25 per person at the disposal of MO-I/C for meeting expenses(refreshments, stationery and misc. expenses)					48	3.89	24	14.50	48	
<b>Trainings</b>						No of persons trained		No of persons trained		No of persons trained	
District level orientation training for 2 days ANM, MPM Health Worker (Male), LHV, HA (M / F), Nurse Mid Wives, BEEs & other specialist ( as per RCH norms)	As per revised norms for trainings under RCH					11000	1.45	2000		1000	

**Table-10**

Service Delivery: -	Norms*	Expenditure & Achievement									Remarks
		2005-06	2006-07	2007-08	2008-09		2009-10 (till Dec'09)		2010-11		
		Expenditure	Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
Three day training of <b>Medical Officers on RI</b> using revised MO training module	As per revised norms for trainings under RCH			<b>2.11</b>		No of persons trained 0		No of persons trained 116	<b>14.50</b>	No of persons trained 5000	
One day refresher training of <b>District RI Computer Assistants</b> on RIMS/HMIS and Immunization formats under NRHM	As per revised norms for trainings under RCH								<b>0</b>		
One day <b>Cold Chain handlers training</b> for block level cold chain handlers by State and District Cold Chain Officers and DIO for a batch of 15-20 trainees and three trainers	As per revised norms for trainings under RCH				<b>8.7</b>	No of persons trained 118	<b>6.83</b>	No of persons trained 605	<b>8.7</b>	No of persons trained 600	

Service Delivery: -	Norms*	Expenditure & Achievement									Remarks
		2005-06	2006-07	2007-08	2008-09		2009-10 (till Dec'09)		2010-11		
		Expenditure	Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
One day Training of <b>block level data handlers</b> by DIO and District Cold chain Officer to train about the reporting formats of Immunization and NRHM	As per revised norms for trainings under RCH					No of persons trained		No of persons trained		No of persons trained	
<b>Microplanning</b>						<b>29</b>		<b>29</b>		<b>29</b>	
To develop sub-center and PHC microplans using bottom up planning with participation of ANM, ASHA, AWW	@ Rs 100/- per subcentre (meeting at block level, logistic)							% of SC/PHC/CHC/ Districts have updated microplans this year		% of SC/PHC/CHC/Districts have updated microplans this year	
	For consolidation of microplan at PHC/CHC level @ Rs 1000/- block & at district level @ Rs 2000/- per district										
<b>POL for vaccine delivery from State to Dist &amp; from district to PHC/CHCs</b>	Rs100,000/ district/year				<b>8.53</b>	% Funds used		% Funds used	<b>7.80</b>	% Funds used	
						100	100	100			

**Table-11**

Service Delivery: -	Norms*	Expenditure & Achievement								Remarks			
		2005-06	2006-07	2007-08	2008-09		2009-10 (till Dec'09)		2010-11				
		Expenditure	Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Funds requirement		Target		
Consumables for computer including provision for internet access for RIMS	@ 400/ - month/ district												
<b>Injection Safety</b>						% funds used		% Funds used		% Funds used			
Red/Black Plastic bags etc	@ Rs 2/bags/session		27.50	3.25	2.05								
Bleach/Hypochlorite solution	@ Rs 500 per PHC/CHC per year												
Twin bucket	@ Rs 400 per PHC/CHC per year												
<i>Any State Specific Need with justification (Please provide a separate write-up on objective, strategy, expected output and outcomes, basis for cost estimates etc.)</i>	10 % of total amount of approved PIP					% funds used		% Funds used		% Funds used			

**264.**Reported immunization coverage for fully vaccinated children has shown a slight increase from 71.3 % to 76.7% between DLHS-2 & DLHS -3 surveys .The reported coverage for BCG during the same period has increased from 92.4 % to 96.9 %.and for Measles from 82.4to 90.3 %. This shows that though there is a need for 100% ofBCG coverage (of new born) through increasing trend of Institutional deliveries, there is still work to be done to achieve 100 % Measles (infant) coverage. There has been three case of deaths due to the VPD's. There has been Five Death reported of in **Adverse events following immunization (AEFI)** . (Adverse Event Following Immunization committee has been conducting state level committee meetings. District level AEFI committees are working well).

**265.**11500 Para medics have **been trained in Routine immunization** with standard operating protocols, following which RI micro plans have been prepared with identification of fixed immunization session sites and dates to ensure full coverage through linkup with ASHA, AWW's . MOH training Calendar Events are requested from Districts for the next year.

**266.Biomedical waste management** through safe disposal of waste as per guidelines, into the Pits are planned in all PHC's. Supply of waste collection at generation points through Red & White plastic covers, tin bins, Hub cutters needs to be done. AD Syringes have been supplied for immunization activities.

Table-12

Reporting and Response to Outbreaks and AEFIs for, 2009-10 till Dec 09.

SL. No	Districts	Cases Reported	Deaths	Remarks
1	Belgaum	1 (03-02-2009)	1	FIR,PIR&DIR submitted
2	Chitradurga	1 (03-02-2009)	1	FIR&PIR submitted
3	Hassan	2(1-10-09)	2	FIR&PIR submitted
4	Dharwad	1 (29-04-2009)	1	FIR&PIR submitted

- 2007-08 state level AEFI committee has been formed quarterly once meetings are regularly held
- 2008-09 all district AEFI committees has been, formed regularly meetings are held

- AEFI work shops and training are completed state and districts
- The reporting system improved during 2009-10 total 5 cases of serious case are reported

#### 267. Supervision and Monitoring :

- State level core group committee headed by secretary of Health and family welfare
- Every quarter core group meeting are being conducting and review of routine immunization status is being held
- Under the chairmanship of secretary Health and family welfare District Health and family welfare officers meetings are conducted at the state HQ every month.
- Under the chairmanship of mission director(NRHM) RCH officer(DIOs) Meeting conducted at state for review RI programme
- 29 nodal officer from state HQ. visiting to district every month for supervision of routine immunization.
- Taluka level THOs are monitoring RI programme and reports are submitted to Districts.

#### 268. Strategies for further improving Routine Immunization

- With the help of ICDS Department, in rural areas mobilization by utilizing AWW to session sites
- Creating awareness about RI
- Tracking of children's
- Reporting of AEFI Cases
- Tracking of dropouts
- With the help of private clinics and NGO's RI implemented in urban areas

Table-13

#### FULL IMMUNIZATION IN SOME OF THE POOR PERFORMING DISTRICTS DLHS-2 & 3A COMPARATIVE STUDY

Sl. No.	Districts	DLHS-2		DLHS-3	
		Measles	F I	Measles	F I
1	Bellary	78.01	71.09	82.03	68.06
2	Koppal	54.01	41.07	80.08	73.03
3	Raichur	50.00	42.03	61.03	49.09
4	Gulbarga	53.02	45.01	75.00	68.03
5	Bagalkote	56.01	42.07	72.01	59.08
6	Bijapur	65.02	49.03	62.03	73.08
7	Belagum	57.02	52.06	90.00	63.08
8	Chitradurga	82.08	81.02	84.07	74.02

## **269. Activities envisaged to improve FI**

- a. Reduce dropouts utilizing the social mobilization funds.
- b. Dropouts list are exhibited in VHSC office.
- c. Sensitizing the VHSC members.
- d. Tracking dropout children.
- e. *Creating of awareness among public.*
- f. *involvement of ASHA workers in all sessions*
- g. *workshop to all health workers*
- h. *publicity materials to all PHCs*

### **Activities:**

#### **Alternative Vaccine Delivery:**

**270.** Arrangements will be made to deliver vaccine from PHC to out reach session sites of sub centers other than those sub-centers which are located in PHC head quarters. Amount of 50 Rs per session will be paid for transporting vaccine. Decentralized powers of appointing the person to transport vaccine and ensuring vaccine is delivered in time will be the responsibility of District RCH Officers. Instructed to prepare District Vaccine distribution plan and the name of the person who will distribute the vaccine will be included in the **micro-plan**. The person transporting the vaccine should have his/her own mobility either in the form of two wheeler / cycle.

#### **Mobilizaion of children's through ASHA/AWW/LINKWORKERS:**

**271.** Social mobilization will be done through ASHA worker/AWW/LINKWORKERS or through self help groups each will be paid 100 Rs per session (Max Rs 400/SC) for the activity. This is done to bring in the drop-out minimize, also creating awareness to parents and to ensure that the immunization schedule is upheld for each eligible child. Instructed to District Immunization officers involvement with VHSC members and Drop outs list shall display in Gram Panchayths.

#### **Focus on Slums & Underserved areas in urban areas:**

**272.** Contracting of an ANM/LHV/Jr health assistant(M)/Private clinics/Private Nursing Homes / NGO to plan and hold immunization sessions in urban areas where there is no existing Govt health set up with an ANM. One session for every 10,000 population will

be held in urban slums / underserved areas and in earlier PPC covered areas. Each session paying for 300+50 contingency. Organized workshops for General Practitioner's, NGOs, and Nursing Home owners.

**273.** Training, monitoring and supervision of the staff working in these allotted areas will be done by concerned district Level Officers, THO and if available medical officers of urban centers. The monthly report on performance in these allocated areas will be submitted to the concerned area medical officer, reports will be submitted to concerned taluk health officer. Also it will be made mandatory to attend monthly meeting at either of the places.

**Mobility support for Supervision(Supervisory visits by district level officers):**

**274.** Through provision for POL / maintenance visits to all the immunization sessions can be given. A standard checklist ( Meticulous checklist provided by GOI it was given to districts) for monitoring immunization sessions and visits to PHC and sub – center will be used. The compiled data will be analyzed and problems identified will be discussed for in district level core group meeting

**Computer assistant to DIO:**

**275.** Karnataka has given to each district One computer assistant is provided for RCH officer exclusively for immunization purpose. He will be responsible for collecting reports/ data from taluk level and compile, store and analyse the data at district level and maintain computer data base of all indicators related to immunization. HIMS will be used for this purpose.

**Cold Chain Maintenance:**

**276.** The Cold Chain of all UIP vaccines is being maintained at recommended temperature by ensuring good storage, issue and transportation practices at all levels. We have a good number of functioning walk in coolers / Freezers with 0% break down rate, ILR/DF with 7% breakdown rate and sufficient quantity of Cold Boxes, Vaccine Carriers and Ice packs.

### **277.Strategy for improving Cold Chain:**

- ✚ Reducing down time of ILR /DF.
- ✚ Training Vaccine handlers.
- ✚ Providing Cold Chain Equipments to needy institution.
- ✚ Providing Generator power backup for District Vaccine Stores other than districts having WIC Centers.

### **278.Infrastructure and Manpower requirement:**

- ✚ Building for bulk storage of Vaccine & logistics at state Head quarter and at Regional WIC Centers.
- ✚ Providing services of Refrigerator Mechanic to all the Districts.
- ✚ Providing Refrigerated Van to State Head quarter and Vaccine Van for needy districts for transportation and for distribution of vaccine.

### **Lift vaccines from regional stores to Districts:**

**279.**Five Regional stores are in Karnataka ie Mangalore ,Belgam, Chithradurga, Mysore,and Gulbarga one at state head quarters. Vaccine shifting from Regional stores to Districts providing for funds Maintenance for cold chain and supplying of vaccine with in time.for which POL provision for District Rs. 20,000 /year .state level projected to 2 lakhs.

### **Printing of Immunization Cards/Injection safety:**

**280.**Printing and dissemination of Immunization cards, Tally sheets, monitoring formaets,etc.it is Decentralizing to districts for printing. Injection Safety purpose Red/Black plasticbaga etc. Bleach/Hypochlorite solution procuring purposes it also Decentralizing to Districts.

**Table-14****PROPOSED RCH-II PIP 2010-11: KARNATAKA**

Sessions Held Urban :15867  
 Sessions Held Rural :281474  
 AVD Sessions :264490

		Rs. In Lakhs
Sl. No	ACTIVITY	Approved by GOI
1	Mobility support for supervision at state and district level	14.50
2	Alternative vaccine delivery	132.24
3	Mobilization of children through ASHA/link workers	281.47
4	Focus on slums and underserved areas	63.46
5	Computer Assistant at State and district level	34.80
6	Review meetings at state level	5.00
7	Review meetings at district level	14.50
8	Cold chain maintenance at PHC/CHC, District and AMC charges for WIC/WIF	25.94
9	Cold chain handlers training	8.70
10	RI training of MOs in districts	14.50
11	POL for vaccine delivery from State to districts and PHC	7.80
12	Printing of Immunization cards and monitoring tools	49.00
<b>TOTAL</b>		<b>651.91</b>

## PULSE POLIO

**281.** Polio, the name it self communicates a dread full infection of the young children which finally results in the life long crippling of the affected children. This not only causes financial liability to the family and the society but also leads to a severe mental agony and torture to the child and the family. With the advent of a cost effective and efficient Oral Polio Vaccine the Nation with help of International agencies took upon the challenge of eradicating this dreadful disease from the sub continent. As a result the Pulse Polio Programme was started in the year 1995 in campaign mode, in order to vaccinate all the vulnerable children and protect them from the wild polio virus which causes the diseases. Total 73 lakhs children's are vaccinating every year.

During 1<sup>st</sup> round pulse polio December 2008 98.22% achievement

2<sup>nd</sup> round pulse polio February 2009 100.55% achievement

**282.** No reported polio cases for the past 4 years in Karnataka one indigenous case reported on 2007 in Bangalore (u) it is migrated from UP.MOP up was conducted in DEC 2007. For the next round of Intensive Pulse Polio Programme for sustain zero polio status

### **Training/Review meetings:**

**283.** Every year state level Review/District level Review conducting for state and district level officers for sensitizing of RI. Every month DIOs meetings are conducting in state level. Master training and TOT training has been completed last year this year **planning for** Capacity building workshop on RI for all MO's on areas such as management, including supervisory skills, and technical appropriate issues.

**284.** Training of frontline functionaries in basic concepts about immunization, AEFI , use and safe disposal of AD syringes and use of hub cutters. One day district level training on cold chain for vaccine handlers will be done. The participants will comprise of four persons from each PHC- LHV, HQ ANM, and Staff nurse / SHAM (Sr. Health Asst. Male) & Pharmacist.

**Budget: Rs. 991.00 lakhs**

## Part-D

### CHAPTER-25

#### NATIONAL DISEASE CONTROL PROGRAMMES

#### National Iodine Deficiency Disorders Control Programme & Nutrition:

(100% Centrally Sponsored Scheme)

285. NIDDCP Programme is implemented in the state in order to prevent iodine deficiency disorders like cretinism, deaf mutism, dumbness, physical and mental retardation, goiter, etc. Dakshina Kannada, Udupi, Uttara Kannada, Kodagu, Chickamagalur, Chamarajanagar, Mysore are endemic districts. The sale of non iodized salt is banned under PFA Act in all the districts of the state. The general public is motivated to use only iodized salt. Several health education programmes are taken up to create awareness regarding the use of only iodized salt. Health workers in all the 29 districts of the state are trained regarding the programme.

**Table-15**

#### **BUDGET UNDER NIDDCP**

(Rs. In lakhs)

Code	Activitiy	Unit cost	No. of units	Amount proposed	Amount approved
D1	IEC Activities			12.50	12.00
D2	Conducting of Re-survey	0.50	5	2.50	2.50
D3	<b>Establishment of IID cell at State level</b>				
D3.1	Technical officer (regular staff)	2.40	1	2.40	6.00
D3.2	ASO (regular staff)	2.40	1	2.40	
D3.3	Clerk cum typist (regular staff)	1.45	1	1.45	
D 4	<b>Establishment of IID monitoring lab at State level</b>				
D 4.1	Lab technician	2.40	1	2.40	3.50
D 4.2	Lab attender	1.85	1	1.85	
D 5	Contingency	0.50		0.50	
	<b>Total</b>			<b>26.00</b>	<b>24.00</b>

Additional budget related to maternal health and nutrition budgeted under RCH & NRHM additionalities budget heads

	<b>Activities</b>	<b>Unit Cost</b>	<b>No. of units</b>	<b>CSS</b>
A 13.2.5.7	Vitamin A Procurement (Under RCH flexi pool)	0.0005	2,40,000	120.00
	<b>Total</b>			<b>120.00</b>

## CHAPTER-26

### INTEGRATED DISEASE SURVEILLANCE PROJECT (IDSP)

#### **Project Objectives**

**286.** To establish a decentralized state based system of surveillance for communicable and non-communicable diseases, so that timely and effective public health actions can be initiated in response to health challenges in the country at the state and national level.

**287.** To improve the efficiency of the existing surveillance activities of disease control programs and facilitate sharing of relevant information with health administration community and other stakeholders so as to detect disease trends over time and evaluate control strategies.

#### **Specific Objectives**

- To integrate and decentralize surveillance activities.
- To establish systems for data collection, reporting, analysis and feedback using Information Technology.
- To improve laboratory support for disease surveillance.
- To develop human resources for disease surveillance and action;
- To involve all stakeholders including private sector and communities in surveillance.

#### **288. Project Activities**

##### **Up gradation of Laboratories**

- Renovation & Furnishing of labs.
- Supply of Lab Equipments.
- Lab. Material and Supplies.

##### **Information Technology and Communication**

- Computer Hardware & Office Equipments
- Software for surveillance.
- Leasing of Wide Area Networking.

## **Human Resources & Development**

- Consultant/ Contract Staff.
- Training.
- Information, Education & Communication.

## **Operational Activities & Response Monitoring & Evaluation**

### **Diseases covered under IDSP**

#### **Regular Surveillance**

1. Malaria.
2. Acute Diarrheal Disease (Cholera)
3. Typhoid.
4. Tuberculosis.
5. Measles.
6. Polio.
7. Road Traffic Accidents (Linkup with Police computers)
8. Plague.
9. Meningoencephalitis/ Respiratory Distress, Hemorrhagic fevers, other undiagnosed conditions.

#### **289. Sentinel Surveillance**

10. HIV/ HBV, HCV.

#### **290. Other Conditions**

11. Water Quality, Fluorosis.
12. Outdoor Air Quality (Large Urban Centers)

#### **291. Regular periodic survey**

13. Anthropometry, Physical Activity Blood Pressure, Tobacco, Nutrition, Blindness.

#### **292. State Priority diseases.**

14. Filariasis.
15. Kyasanur Forest Disease.
16. Handigodu Syndrome.
17. Leptospirosis.

## Reporting Units for Disease Surveillance

<b>Rural</b>	<b>Public Health Sector</b>	<b>Private Health Sector</b>
	PHC's / CHC's / Sub-district and District Hospitals	Sentinel Private Practitioners and Sentinel Hospitals
<b>Urban</b>	Urban Hospitals, ESI, Railway, Other Hospitals Medical Colleges.	Sentinel Private nursing homes, Sentinel Private Medical Colleges NGOs, Private Laboratories.

### **293. Involvement of Private Sector**

- Strategic Alliance through Professional Association (IMA, IAP).
- Selection by volume of target diseases, geographical coverage, credibility and willingness to participate.
- Providing linkages through web or Transmission by e-mail, Fax/telephone/courier.
- Recognition and Partnership.

### **294. Original Project Development objectives (PDO's) and scope**

The original project development objective was to improve the information available to the government health services and private health care providers on a set of high priority diseases and risk factors, with a view to improving the on the ground responses to such diseases and risk factors.

The five year project (launched in 2004) was to support the longer-run program to consolidate and integrate disease surveillance in the country. The new integrated disease surveillance system was to put greater emphasis on building the links between the collection and analysis of information and the actual on the ground interventions (medical or otherwise) by the public and private sectors. The long run goal was to effect a complete shift from the present centrally driven, fragmented disease surveillance system, to an integrated disease surveillance and control program coordinated by the center but fully implemented by the States, districts and communities.

## **295. Training**

GOI has released a sum of **Rs. 16.20 lakhs** for Training of Hospital Doctors, Pharmacists / Nurses and also Medical College Doctors, Pharmacists' / Nurses/ Medical Record Technician / Data Entry Operators/ Data Managers and Block Health Team under IDSP for Outbreak Report and Analysis. The above said grants of **Rs. 16.20 lakhs** will be released to SIHFW, Magadi Road, Bangalore to undertake the Training Programme.

i. Training of Hospital Doctors	– 4.46 lakhs
ii. Training of Hospital Pharmacist / Nurses	– 6.09 lakhs
iii. Training of Medical College Doctors	– 1.20 lakhs
iv. Training of Medical College Pharmacist / Nurses / Medical Record Technicians	– 0.35 lakhs
v. Training of Block Health Team	– 3.04 lakhs
vi. Training of Data Managers and Data Entry Operators	– 1.04 lakhs

## **296. Staff Salary**

### **Payment to Epidemiologist, Microbiologist and Entomologist appointed by GOI**

GOI vide letter DO No. T.18015/11/2004-IDSP. Dt. 19-02-2009 has appointed Epidemiologist, Microbiologist & Entomologist and posted to various districts and released a sum of **Rs. 85.20 lakhs** towards salary component for payment of remuneration of contractual staff.

To facility payment of salary budget, grants have been released to concerned district societies to disburse salary. Professional tax should be recovered from the salary of the candidate and he should be asked to file income tax returns regularly. Income tax amount may be recovered if they are liable to pay income tax.

## **297. Community Surveillance**

GOI has released a sum of **Rs.1.85 lakhs** for community surveillance and sensitization programme at PHC level. Therefore, the grants will be released to District Surveillance Officer for undertaking Community Surveillance Programme at Chamrajnagar District.

### **298. Outbreak Investigation**

GOI has released a sum of **Rs. 1.45 lakhs** for participation in outbreak investigation and reporting. Budget grants will be released to District Surveillance Officers of Concerned Districts where Government Medical colleges are functioning. DSO will further release the grants to Principals of Government Medical Colleges for participation in outbreak investigation and reporting at **Rs. 5,000** per outbreak limited to 2 outbreak per year.

### **299. ASHA Incentives for Outbreak reporting**

GOI has released a sum of **Rs.3.48 lakhs** as incentive for involving ASHA workers for Outbreak reporting thus facilitating speedy Outbreak reporting to State Surveillance Unit/ Central Surveillance Unit. The grants will be released to concerned District Surveillance Officers for payment to ASHA workers who are involved in outbreak report at **Rs. 100** for each outbreak report.

### **300. Referral Lab Network**

GOI has released a sum of **Rs. 40.00 lakhs** that is **Rs. 5.00 lakhs** per referral lab working at 8 Government Medical Colleges for Strengthening of Outbreak Reporting and feedback. The Grants will be released to District Surveillance Officers of Concerned Districts where Government Medical colleges are functioning. DSO will further release grants to Principals of Government Medical Colleges for undertaking network system for above said purpose for the following Government Medical Colleges.

1. Bangalore Medical College, Bangalore
2. Mysore Medical College, Mysore
3. KIMS, Hubli
4. VIMS, Bellary
5. Mandya Medical College, Mandya.
6. Belgaum Medical College, Belgaum
7. Bidar Medical College, Bidar
8. Raichur Medical College Raichur

### **301. Printing of Reporting Forms**

GOI has released a sum of **Rs. 3.40 lakhs** towards printing of outbreak and FIR reporting formats at **Rs. 10,000** per district and also for 8 Government Colleges per year. Therefore grants will be released to concerned District Surveillance Officers for undertaking the printing of reporting forms.

### **302. Mobility Support**

GOI has released a sum of **Rs.34.80 lakhs** towards the mobility support District Surveillance Officers for visits to CHC's / PHC's and outbreak report. At **Rs.1000** per visit X 10 visits/per month per District. The grants will be released to concerned district Surveillance Officer for implementing the program towards hiring of Private Vehicles and other incidental charges.

### **303. Contingencies**

For effective functioning of surveillance units, following operational expenditure incurred specifically for implementing the Project can be met out of grants released. A sum of **Rs. 2000 pm** for each District Surveillance Units and **Rs. 5000 pm** for State Surveillance Units has been earmarked. Hence, the expenditure may be incurred as follows:

- a) Office expenses including stationery, office consumables items, telephone, electricity
- b) Travel cost, POL, maintenance of vehicles attached to the Project or hiring of vehicles,
- c) Operation and maintenance of equipment purchased under the Project.
- d) Operation and maintenance of facilities renovated under the project.
- e) Expenditure on maintenance of hardware, data collection
- f) Domestic travel costs and per diem as per State rates

Funds for Contingencies are released to the State / Districts in 1-2 installments every year.

### **304. Consumables & Kits for Lab**

GOI has released a sum of **Rs. 4.00 lakhs** for purchase of Consumables and a sum of **Rs. 1.74 lakhs** for collection and transportation of samples for testing. Therefore, the amount has been divided and distributed to 29 Districts and PHI to facilitate specimen testing at laboratories. Procurement should be undertaken by National Shopping method based on comparing price

quotations obtained from several national or international suppliers, usually at least three to ensure competitive prices.

1. Request for quotation shall be by letter (with proof of receipt and record keeping)
2. The request shall include the description and quantity of the goods as well as the required delivery time and place for the goods or services, including any installation requirements appropriate
3. the request shall indicate the date by which the quotations are needed
4. Requests should be addressed to more than three firms that are reputable, well established and are suppliers of the goods or services being purchased, as part of their normal business (after verifying whether those being invited will make an offer or not) to ensure at least three quotations are received.
5. Quotations should be submitted in writing (copies to be kept for records)
6. No bid or performance securities are required.
7. Requests for quotes should indicate the expected date of submission of quotes within one or two weeks of the initial request.
8. If the Purchaser has not received at least three quotations within the time set, it should verify with the suppliers who have not submitted quotation, whether they intend to do so and how soon. Unless there is extreme urgency or there are already three or more quotations available, reasonable amount of additional time, say three more days, could be given to submit quotation.
9. Quotation should be compared after adding to the quoted price for goods, the estimated cost of inland transportation and insurance, if any, to the final destination. The lowest priced responsive offer is selected
10. Purchaser may exercise discretion in selecting quotation that is not the lowest priced as far as there is good justification. For example a slightly higher price may be justified for faster delivery or immediate availability in case of extreme urgency, when late delivery may result in heavy consequences for the purchaser. In such cases, the intention should be indicated in the request for quote
11. Award decision and its rationale should be documented / and kept for review. The record should contain the list of firms invited, and the list and value of quotations received, comparative statements etc. The documents should clearly show that the award is based on sound economic criteria.

**12.** Purchase order shall incorporate the terms of accepted offer and should specify the currency of payment (which is the currency of the quote). Bank accepts payments in any currency of the member countries.

## Chapter-27

### NATIONAL VECTOR BORNE DISEASE

#### CONTROL PROGRAMME

#### 305.MALARIA

The following regular activities are implemented for malaria control in the state.

- 1) Appropriate Detection and Treatment of Malaria Cases:
- 2) Integrated Vector control/management.

**A. Indoor Residual spray:**

**B. Bio-environmental control activities:**

**C. Insecticide Treated bed nets.**

**D. Vector control/anti larval measures in urban and peri urban areas.**

- 3) Advocacy to remote community awareness for Behavioural Change Communication.
- 4) Capacity Building:
- 5) Management Information System

#### 306. The revised activities under Malaria Component for NRHM-NVBDCP are as follows:

##### 1. Training:

The Training programme will be taken up in districts and the details are as follows:

- a) **Training for Medical Officers:** 3 Batches of Training at 25 per batch of 3 days each is proposed to be taken up at State Head Quarters in coordination with ROH & FW as per curriculum. **Each batch is allocated with Rs. 1.20 lakhs and the bifurcation of sub components are enclosed. The total allocation for training is Rs. 3.60 lakhs.**
- b) **Training of Jr. Lab Technicians:** 4 batches at 20 per batch are now proposed for training by utilizing the services of Central Malaria Laboratory of the State HQs as well as the faculty of Regional Director's Office. **The induction level training is for 10 days and an amount Rs. 1.5 lakhs per batch is earmarked for the purpose (bifurcation enclosed). The total allocation for training is Rs. 6.00 lakhs.**
- c) **Training of MPWs:** The Training will be held at the respective district levels, each batch with 25 participants and for 2 days period. 30 such batches are proposed during 2010-11. **An amount**

**Rs. 0.20 lakhs per batch is earmarked for the purpose. The total allocation for training is Rs. 6.00 lakhs.**

- d) **ASHA training:** 20 districts have been identified for training the ASHAs to perform as a kiosk for NVBDCP activities in problematic areas of the state. 12400 ASHAs will be trained at a per diem of **Rs. 100 and Rs. 12.40 lakhs has been earmarked for the purpose.** Guidelines have also been circulated to all the concerned District Malaria Officers for taking up the programme.

**Therefore, the Training Component activity has been proposed and the budget details worked out at Rs. 28.00 lakhs.**

## **2. Contractual Engagement of Malaria Workers**

Though this component was not included in the original PIP of the State, the GOI has considered it necessary to engage these workers in remote problematic areas as well as in areas where there are large number vacancies of Jr. Health Assistants causing lack of EDCT activities, as a common principle to all states. Therefore 100 such malaria workers are to be engaged for the state at Rs. 6000 per month for 9 months during 2010-11. The areas and number of workers to be engaged in such districts is already identified and under process. The statement showing the details is enclosed. **The total allocation under this activity is Rs. 54.00 lakhs.**

## **3. Monitoring and Evaluation & Management Information System:**

The streamlining of data compilation and uploading in web-based NAMMIS along with Monitoring and Evaluation of activities including reporting in revised formats, has been given priority under the component. Considering various constraints faced at the district level for complete operationalization of NAMMIS, the activities like AMC to Computers, Internet connectivity provisions, District level staff training, are proposed for 2010-11. **The total allocation under the component is 18.75 lakhs.**

## **4. IEC/BCC and PPP**

IEC activities have been proposed to be taken up with participation of local Panchayats for Social Mobilization and Community Awareness through Intersectoral Coordination and Advocacy Sessions. However, it has been approved and recorded in the ROP that, a part of this allocation should be utilized against the shortfalls of IEC in Filariasis component where Mass Drug Administration (MDA) is to be taken up. **Therefore out of a total of Rs 35.00 lakhs provided under the activity only Rs. 9.00 lakhs has been earmarked for this activity under Malaria component and the balance of Rs. 26.00 lakhs is transferred to ELF (Filariasis) component for MDA 2010.** Therefore the IEC activities like Anti Malaria Month programme, press releases, TV/AIR spots and relays, intersectoral coordination and advocacy sessions have been planned.

## 5. Procurement Plan under Malaria Component:

The commodities that have been decentralized during 2010-11, are proposed for procurement by the State. However, the GOI is yet to send the guidelines of decentralized items to be procured by the state during 2010-11.

The logistic requirement estimates as worked out by the state during the original PIP is : Rs. 164.18 lakhs. However, this will now be limited to Rs. 89.46 lakhs for procurement of Antimalarial drugs, Larvicides, Adulticides, Fogging chemicals. In case of any exigencies the Rapid Diagnostic Test kits and Bed nets also proposed for procurement during the current year under the said allocations.

### **The total allocation under Malaria component is therefore approved as follows**

1. Training :	Rs. 28.00 lakhs
2. Contractual Malaria Workers:	Rs. 54.00 lakhs.
3. IEC/BCC and PPP:	Rs. 9.00 lakhs
4. M& E and MIS	Rs 18.75 lakhs
5. Procurement od decentralized items:	Rs. 89.46 lakhs.

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**Total** **Rs. 199.21 lakhs**

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## **306. LYMPHATIC FILARIASIS ELIMINATION (Filaria component):**

### **LF elimination:**

**Objective:** To eliminate transmission of LF, to reduce and prevent morbidity in affected persons, and to strengthen the implementation through the primary health care services.

### **Strategies:**

- Single day mass therapy with DEC at a dose @ 6mg/kg body weight annually adjusted to different age groups.
- Management of acute and chronic Filariasis and self-care methods at doorstep.
- IEC for inculcating individual / community based protective and preventive measures for filarial control.
- Anti-vector measures to continue in endemic areas and microfilaria carriers detected in filarial clinics and elsewhere to receive the standard dose of DEC @ 6 mg / kg body wt. per day for 12 days.

### **307. Activities for Lymphatic Filariasis Elimination**

Districts of Bagalkot, Bidar, Bijapur, Gulbarga, Raichur, D. Kannada, Udupi and U. Kannada have been involved in the Mass Drug Administration (MDA) with Di-ethyl Carbamazine (DEC) under Elimination of Lymphatic Filariasis (ELF). Six rounds of MDA have been completed in these districts. During 2010 -11 since Gulbarga has been bifurcated into Gulbarga and Yadgir districts, 9 districts are now considered for MDA during Nov/Dec 2010. Therefore within the available approved grants of ROP the allocations have been duly made.

#### **1. District level Coordination committee meetings**

An amount of Rs. 10,000/- is earmarked to meet the operational contingencies for conducting the District level Co-ordination Committee meetings for each district. Total allocation is Rs. 0.90 lakhs.

Rs. 0.50 lakhs is also provided for conducting 2 state level meetings for pre and post MDA review.

#### **2. Training Component:**

The funds are released for taking up the Training programmes for the PHC Medical Officers and for the Para Medical Staff in the identified MDA areas of the District. Training of MO PHC will be taken up state level while Para Medical training will be held at the respective districts.

**Amount allocated for training of MO PHC is 3.20 lakhs and Rs 1.8 lakhs for Para Medical. Total amount of Rs. 5.00 lakhs has been earmarked for training programmes.**

#### **3. Night Blood Survey:**

The Blood survey is to be taken up before MDA in 4 high incidence (high Mf rate/high LF cases) Fixed Centres of which 3 centres will be rural and 1 centre will be urban. Similarly 4 random centres with high incidence have to be selected, 3 rural villages, 1 Urban area for assessment. Four survey staff are allowed for each survey which may include Sr. HA, Lab Techn, and Jr. HA. The details of TA, Honorarium and other sub-components are as follows:

TA @ Rs. 200 x 4 persons x 8 sites	Rs. 6,400
Honorarium @ Rs. 125 x 4 persons x 3 days x 8 sites	Rs. 12,000
Replenishment of slides, needles cotton, spirit, stain etc.	Rs. 24,600
Contingency @ Rs. 500 x 8 sites	Rs. 4000

<b>Total</b>	<b>Rs. 47,000</b>
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**The total allocation for 9 districts is Rs. 4.23 lakhs.**

**4. Information Education and Communication:**

An amount of Rs. 26.00 lakhs has been earmarked (transferred from the IEC malaria component as per approved ROP). Which is distributed as state and district level activities at Rs. 10.00 Lakhs and Rs. 16.00 lakhs respectively. GOI has already issued guidelines on pre MDA IEC activities to be taken up at these levels.

**5. Morbidity management camps and Hydrocelectomy operations**

A) Fresh Line listing and mapping has to be carried out from the grants released under the component. Line listing is a very important component under MDA hence an amount Rs. 3000 can be utilized for fresh line listing and compilation of all the old cases. Compiled report of both fresh and old cases has to be submitted before 30 days of MDA programme.

Remaining funds can be utilized for campaigning and attracting disease cases to camps, towards purchase of morbidity management materials for every individual case, side reaction management and other operational contingencies.

**An amount of Rs. 1,85,750 is earmarked for the above activity.**

B) Hydrocelectomy operations: The break up for operating one hydrocelectomy case is as follows (new component):

Incentive for Surgeon	Rs. 250
Incentive to Staff Nurse	Rs. 50
Ward boy / attendant (2) @ Rs. 25 each	Rs. 50
Medicine/dressing/suture and follow up medicine	Rs. 300
Transport charges to patient	Rs. 100
Total	Rs. 750

**An amount of Rs. 1,67,250 has been earmarked for the activity.**

**6. Drug distributors and Supervisors honorarium**

As per the guidelines of GOI 56,000r Drug distributors are required as per the estimated target beneficiaries, with 5600 supervisors. However, since the allocation under this component have been cut down under the ROP, the same has been revised at 50,000 Drug Distributor and 5000 Supervisor which indicates a shortfalls of 6600 workers/volunteers for the programme.

**A total allocations of Rs. 50.00 lakhs as Drug Distributor honorarium and Rs,. 6.25 lakhs as Supervisors honorarium.**

**7. POL/Transport Charges:**

The POL charges/Transport charges are provided as per sub centre requirements. Side reaction management teams are also to be provided with transport charges/facilities for management of such cases. However, the micro-level allocation can be effectively planned by the District Malaria Officer/Dist. Executive Committee, for optimum utilization.

**An amount of Rs. 7.30 lakhs has been allocated for the component.**

**8. Monitoring & Evaluation - External:**

The external evaluation is being done through the Sr. Director's office by utilizing the services of Medical College faculty already identified for the purpose. Rs 9,000 per district per evaluation team is earmarked and total of Rs. 81,000 is allocated for the purpose.

The monitoring of MDA activities by external agency is also being done by the staff of Community Medicine Dept. in various Medical Colleges during the MDA progress. **Rs. 1.48 lakhs has been allocated for the purpose.**

**A total of Rs. 2.29 lakhs is therefore earmarked for external M & E activity.**

The Drug Distributors' training component has been deleted in the approved ROP. The allocations for transport and Morbidity Management are insufficient and needs to be supplemented during the implementation of the programme according to the needs.

**The total allocation for ELF Filaria component is Rs. 106.00 lakhs.**

**DENGUE / CHIKUNGUNYA – Prevention and Control**

**308.**

**Interventions Planned:**

**1) Grant-in-aid contingency for SSH & ARL:**

GOI has allocated Rs. 8.00 lakhs for this component for release of 0.50 lakhs each to 14 Sentinel Surveillance Centres/Hospitals (SSHs) and Rs. 1 lakh to Apex Referral Laboratory at NIMHANS.

However, at present only 7 SSHs are functioning in the state and they have been allocated with Rs. 0.50 lakhs each and Rs. 1.00 lakh for Apex Referral Laboratory. Hence a total of Rs. 4.5 lakhs has been allocated for this component. Remaining 7 SSHs will be identified during last quarter in consultation with Sr. Regional Director's office after assessing the incidence during the epidemic season and the amounts will be released accordingly.

2) **Training of medical officers at Rs. 11.10 lakhs.**

The Training programme will be taken up in districts and the details are as follows:

a) **Training for Medical Officers:** 2 Batches of Training at 25 per batch is proposed to be taken up at State Head Quarters in coordination with ROH & FW as per curriculaum. **Each batch is allocated with Rs. 1.20 lakhs and the bifurcation of sub components are enclosed. The total allocation for training is Rs. 2.40 lakhs.**

b) **Training of Para Medical Staff**

Thirteen districts have been allotted with an amount of Rs. 20,000 each for taking up 2 days training for the newly recruited and untrained para medical staff.

**The total allocation for training is Rs. 5.00 lakhs.**

3) **IEC activities:**

IEC activities have been proposed to be taken up by the state for printing of IEC materials and distribution to the periphery, TV/AIR spot relay etc. **An amount Rs. 7.00 lakhs is earmarked for this activity.**

4) **Monitoring and evaluation & Rapid Response by district and State level:**

Prevention and control activities carried out at periphery level has to be monitored and supervised for their effective implementation both at District and State level. This activity includes Strengthening of M & E, POL, Transport etc. An amount of Rs. 0.20 lakhs each has been allotted to districts amounting to Rs. 6.00 lakhs while Rs. 11.00 lakhs, has been earmarked for state level activities.

**A total of Rs. 17.00 lakhs has been allotted for the above component.**

5) **Epidemic Preparedness:**

Under this component activities like preventive campaigning, monitoring epidemic preparedness, vector control activities and Emergency intervention including house to house Aedes surveillance and source reduction activities will be taken up. Guidelines have already been prepared and circulated to the District Malaria Officer for implementation.

All the districts have been allotted with an amount of Rs. 0.25 lakh each to carry out the above activity amounting to a total of Rs. 7.50 lakhs and Rs. 7.50 lakhs has been earmarked for State level activity.

The state had proposed Rs. 37.80 lakhs towards Epidemic Preparedness in order to take up preventive activities which included Aedes source reduction. However, this has been reduced to Rs. 15.00 lakhs with a shortfall of Rs. 22.80 lakhs. Therefore the districts have been allocated only to use it during emergency intervention and Rapid Response. State will further release additional funds from its allocation depending on the local situations in case of such exigencies.

**A total of Rs. 15.00 lakhs has been earmarked for the activity.**

**The total grants for 2010-11 under Dengue/Chikungunya component is Rs. 52.00 lakhs.**

#### **4. JAPANESE ENCEPHALITIS**

**309.** Areas Prioritized for JE prevention and control activities are Bijapur, Bagalkot, Bellary, Chitradurga, Davanagere, Gulbarga, Yadgir, Kolar, Koppal, Mandya, Raichur and Chikballapur districts.

##### **1. Strategy and innovations proposed:**

- A) JE vaccination campaign in Gulbarga, Bagalkot and Chitradurga districts through Project Director (RCH).
- B) Strengthening of routine immunization to include JE vaccine in Bellary, Kolar, Raichur, Koppal, Mandya, Dharwad and Bijapur districts
- C) Strengthening of AES surveillance in all the districts
- D) Strengthening of integrated vector management
- E) Capacity building regarding case management
- F) Rehabilitation of affected cases

##### **2. Activities Planned:**

###### **1. Training of MO PHC:**

3 Batches of Training at 20 per batch is proposed to be taken up at State Head Quarters in coordination with ROH & FW as per curriculaum. **Each batch is allocated with Rs. 1.00 lakhs and the bifurcation of sub components are enclosed. The total allocation for training is Rs. 3.00 lakhs.**

**2. AES strengthening:**

Intensification of AES surveillance would be taken up in all districts under state level monitoring. Rs. 8.00 lakhs has been earmarked for the same.

**3. Monitoring & Evaluation:**

M & E strengthening would be taken up by printing of reporting formats, JE management charts/Books for distribution to small hospitals in JE prone districts. POL support and transport cost will also be met under the component. Rs. 2.00 lakhs has been allotted for this component.

**4. IEC activities:**

Health education materials are planned for use in JE Vaccinated areas (follow-up) and for campaigning on preventive aspects. Amount of Rs. 3.00 lakhs earmarked under this activity.

**5. Technical Malathion:**

Rs. 1.00 is allocated for the state to meet the cost of Technical Malathion which is outdoor fogging chemical, for emergency intervention in JE prone areas.

**Total allocation for JE component during 2010-11 is Rs. 17.00 lakhs**

**Therefore, the budget grants for 2010-11 under NRHM-NVBDCP for KARNATAKA as per ROP is as follows:**

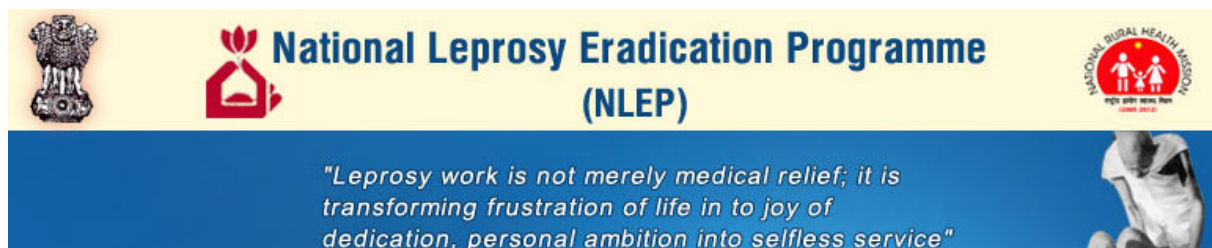
<b>1. Malaria :</b>	<b>Rs. 199.21 lakhs</b>
<b>2. Filaria :</b>	<b>Rs. 106.00</b>
<b>3. Dengue/Chikungunya:</b>	<b>Rs. 52.00</b>
<b>4. JE:</b>	<b>Rs. 17.00 lakhs</b>

**Total for NRHM-NVBDCP Components only: Rs. 374.21 lakhs**

Commodity support by GOI for VBD = Rs.163.20/- Lakhs.

Total Cash + Commodity assistance = Rs. 537.41/- Lakhs.

## Chapter-28



### LEPROSY :

**310.** Leprosy is a chronic infectious disease caused by *M. leprae*, an acid-fast, rod-shaped bacillus. The disease mainly affects the skin, the peripheral nerves, mucosa of the upper respiratory tract and also the eyes, apart from some other structures.

#### **Dr. GHA Hansen, in his younger days.**

**1872** Hansen identifies *Mycobacterium leprae* microscopically and publishes report on it 1 year later. Leprosy will later be named, “Hansen’s Disease” in recognition of his efforts, as well as attempting to reduce the stigma associated with the word leprosy.



#### **311. CARDINAL SIGNS FOR THE DIAGNOSIS OF LEPROSY:**

**312.** Hypo pigmented or reddish skin lesion (S) with definite sensory deficit.

**313.** Involvement of the peripheral nerves, as demonstrated by thickening with definite loss of sensation and weakness of the corresponding muscles of the hands feet or eyes.

**314.** Demonstration of *M. leprae* in the lesions. The first two cardinal signs can be identified by clinical examination alone while the third can be identified by examination of the slit skin smear.

### A guide for clinical classification

	Paucibacillary leprosy (PB)	Multibacillary leprosy (MB)
Skin lesions	1-5 lesions	More than 5 lesions
Peripheral nerve	Only one nerve involvement	More than one nerve
Skin smear	Negative at all sites	Positive at all sites

### Treatment

<p><b>Dosage (Adult MB) :</b></p> <p><b>Monthly Treatment: Day 1</b></p> <p>Rifampicin 600 mg</p> <p>Clofazmine 300mg</p> <p>Dapsone 100mg</p> <p><b>Daily Treatment: Days 2-28</b></p> <p>Clofazmine 50mg</p> <p>Dapsone 100mg</p> <p><b>Duration of treatment</b></p> <p>12 blister packs to be taken monthly within a maximum period of 18 Months.</p>	<p><b>Dosage (Adult PB) :</b></p> <p><b>Monthly Treatment: Day 1</b></p> <p>Rifampicin 600 mg</p> <p>Dapsone 100mg</p> <p><b>Daily Treatment: Days 2-28</b></p> <p>Dapsone 100mg</p> <p><b>Duration of treatment</b></p> <p>6 blister packs to be taken monthly within a maximum period of 9 Months.</p>
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### National Leprosy Eradication Programme in Karnataka

National Leprosy Control Programme was started in 1955 in Karnataka based on Dapsone domiciliary treatment through vertical units implementing Survey Education and Treatment activities. The Multi Drug Treatment (MDT) came into wide use from

1986. MDT programme was started in Belgaum & Dharwad districts during 1986-87, in Raichur , Gulbarga Bidar & Mysore , during 1988-89, in Bijapur & Bellary during 1990-91 and started in all the districts of Karnataka during 1992-93. Based on this programme and following the Govt. of India Guidelines, National Leprosy Eradication Programme was launched in Karnataka with the objective of arresting the disease activity in all the known cases of leprosy. This Programme was a 100% Centrally Sponsored Scheme.

The National Leprosy Eradication Programme has made tremendous progress in Karnataka. The disease has come down to level of elimination i.e. less than one case per 10,000 population at the state level by March 2005. Still the disease is prevalent with more than one case per 10000 population in two districts. Since the Programme aims for eradication i.e. zero endemicity of leprosy as the ultimate goal sustained control measures need to be continued.

#### **NLEP- Objectives:-**

- Further reduce the leprosy burden in the State.
- Provision of high quality leprosy services for all persons affected by leprosy, through General Health Care System including referral services for complications and chronic care.
- Enhanced Disability Prevention and Medical Rehabilitation (DPMR) services for deformity in leprosy affected persons.
- Enhanced advocacy in order to reduce stigma and stop discrimination against leprosy affected persons and their families.
- Capacity building among Health Service personal in integrated setting both for Rural and Urban areas.
- Strengthening the monitoring and supervision component of the surveillance system.

#### **NLEP – Strategy**

- ✓ Decentralization of NLEP to Districts
- ✓ Integration of leprosy services with General Health Care System (GHS)
- ✓ Leprosy Training of GHS functionaries
- ✓ Early diagnosis & prompt MDT, through routine and special efforts
- ✓ Information Education and Communication (IEC) using Local & Mass Media for reduction of Stigma & Discrimination.

- ✓ Prevention of Disability & Medical Rehabilitation.
- ✓ Monitoring & Periodic Evaluation
- ✓ Inter-sectoral collaboration

### Expected Outcome

The system of setting targets for leprosy case detection, case treatment and discharge of patients is not being followed in the National Leprosy Eradication Programme in India from the year 2003-04 onwards. These targets are no longer of much use after elimination of leprosy as a public health problem at the National level.

<b>Indicators</b>	<b>2007-08</b>	<b>2008-09</b>	<b>Expected outcome during 2009-10.</b>	<b>Expected outcome during 2010-11.</b>
<b>PR/10000</b>	<b>0.51</b>	<b>0.50</b>	<b>0.48</b>	<b>0.45</b>
<b>ANCDR/100000</b>	<b>7.50</b>	<b>7.27</b>	<b>7.00</b>	<b>6.5</b>
<b>Cured rate MB</b>	<b>86.10</b>	<b>98.00</b>	<b>100%</b>	<b>100%</b>
<b>Cured rate PB</b>	<b>96.70</b>	<b>99.00</b>	<b>100%</b>	<b>100%</b>
<b>No. of Gr. II disabled cases</b>	<b>0.86</b>	<b>1.18</b>	<b>1.00</b>	<b>1.00</b>

### Magnitude of the problem

At the time of starting MDT during March 1986, there were 152642 cases of leprosy and the PR was 40/10000 population. By March 2009 total patients load was 3002 with PR of 0.50/10,000 population. New cases detected during 2008-09 was 4411, the cases cured during 2008-09 were 4277. Annual New Case Detection Rate (ANCDR) was 7.14/100000 population. The percentage wise break up of New cases were as follows:

Female - (37.56%), MB (57.76%),  
 Child (11.81%) Visible Deformity (Gr-II) (1.61%),  
 Schedule Tribe (34.6%) Scheduled Caste (13.71%). RFT (97.18%)

Total 4404 new cases have been detected from April 2009 to March 2010. In Kodagu district only 5 cases have been detected, in 10 districts less than 100 new cases have been detected, less than 200 cases in 11 districts, less than 300 new cases in 4 districts, less than 400 new cases in 2

districts and in only one district Bangalore (Urban) district has reported 405 new cases. There are 2986 cases are on hand as on 31<sup>st</sup> of March 2010. 4236 cases completed the treatment. MB rate is 56.7%, the child rate is 11.82%, Deformity rate is 3.3% & Female rate is 38.9% and Annual New Case Detection Rate (ANCDR) is 7.19/1000000 population. A total of 4404 new cases are on record as on 1<sup>st</sup> April 2010 giving a Prevalence rate of 0.49/10000 population.

At present there are 29 districts in the state. 28 districts have achieved the level of elimination and only 1 districts Dharwad is having PR more than 1/10,000. The PR has drastically come down from 40/10000 population during 1986, to 0.49 /10000 population up to the end of March 2010.

**PR in TALUKS (Blocks) as on 31/3/2010**

Total Taluks	0 PR	Less Than 1	1 to 2	More Than 2
176	10	144	20	2

**PR in Districts as on 31/3/2009**

Total Districts	0 PR	Less Than 1	1 to 2	More Than 2
29	-	28	1	-

**Modified Leprosy Elimination Campaign (MLEC) in Karnataka**

Modified Leprosy Elimination Campaign (MLEC) was started in '98-99 with the objective of creating mass awareness about leprosy in the community, giving orientation training to all general health care staff and conducting house to house search of the population to detect hidden leprosy cases. First round of MLEC was done from 20-04-1998 to 25-04-1998, 36645454 people were examined, 72309 cases were suspected and 9881 cases confirmed and treated. Second round was done on 28<sup>th</sup> and 29<sup>th</sup> of January 2000, 2556 voluntary reporting centres were established and 41713 were suspected and 3752 were confirmed and treated. Third MLEC was done in the year 2001, 3042 voluntary reporting centres were opened, 56650

suspected persons were reported, 2957 cases were confirmed and treated. Fourth MLEC was done from 18-12-2002 to 19-12-2002, 3062 voluntary reporting centres were opened, 69757 suspected persons were reported and 2311 cases were confirmed and treated.

### **Decentralized Planning**

With instruction of the National Rural Health Mission (NRHM) all the activities of National Leprosy Eradication Programme will be planned, implemented and monitored under the umbrella of NRHM. It is envisaged in the NRHM that the districts health plan will be formulated through bottom up and result oriented planning process. For preparing Programme Implementation Plan (PIP) of 2010-11 various steps have been taken and reflects the actual needs of the Districts. The process is coordinated with NRHM and results and indicators are formulated and added in the PIP depending upon the Leprosy Situation in the State. SLO has attended the National Level Decentralized Work Shop conducted by Govt. of India at Jaipur. SLO has organized a similar. Workshop of Decentralized Planning for the DLOs at the State level. The DLOs in coordination with the PHC Medical Officers and Other Stake-holders of the programme prepared District Action Plan and submitted to the state. In consultation with the District Programme Officers the State & AIFO has prepared the PIP for 2010-11.

### **Programme Components**

#### **Block Level Leprosy Awareness Campaign:-**

As the PR was more than 5 in one Block Hadagali in Bellary district Block Level Leprosy Awareness Campaign was conducted from 12-11-2007 to 26-11-2007. The teams were formed consisting of ANM, Anganawadi worker, Male Health worker and Volunteers. One day training was given. The team has visited all the villages in the Block and also visited house to house and created awareness about Leprosy. 111 villages were covered, 178380 population contacted, 34806 houses were covered, 128 Gr. II cases were listed and 25 new cases were reported at the Health care facilities. Intensive IEC, Group meeting and other awareness programmes were done in these villages.

During 2008-09 Block Level Leprosy Awareness Campaign was conducted in 5 districts, 4 blocks in Chamarajanagar, 1 block in Mysore, 1 block in Chitradurga, 4 blocks in Koppal and 3

blocks in Bellary district. 3076270 population was covered. 1877 villages were selected for the campaign, 719218 house holds were visited by the health workers and volunteers. Special IEC done in these villages, 269 Gr. II disability cases were listed, 843 cases were suspected and 171 cases were confirmed and treated.

During 2009-2010 Block Level Leprosy Awareness Campaign was conducted in 7 districts, population covered 1662688, No. of villages covered 1033, 10261 Group meetings were held, 1189976 persons were contacted, 295 Grade II disability cases were listed, 1295 cases suspected for Leprosy and 147 cases were confirmed as Leprosy and treated.

### **Multi Drug Therapy (MDT):-**

Very effective treatment is available for cure of Leprosy Person Affected with Leprosy, is treated with combination of drugs called Multi-Drug Therapy (MDT). MDT is available free of cost at all the health care facilities. Drug is taken orally and is available in blister packs containing drugs for 28 days (four weeks taken as one month of regimen).

For the early detection and prompt MDT Treatment all necessary steps have been taken. The Medical officers and the Para Medical Workers have sensitized for the early case detection and MDT treatment. All the Medical Colleges have been requested to send the report of the cases reported in the colleges. Sufficient stock of MDT drugs are provided to all the Health Care functionaries. Defaulter cases are being traced and complete treatment is given. Accompanied MDT is being given to the needy persons affected with leprosy.

### **IEC Activities:-**

#### **Activities implemented during 1<sup>st</sup> April 2008 to 31 March 09**

<b>S. No</b>	<b>Activities</b>	<b>Activities planned in the year as per IEC plan</b>
1	Hoardings	24
2	Advertisement in print media	49
3	Posters/ Pamphlets	560000
4	Wall Painting	360

5	Rallies & Banner/ Out door publicity	212
6	School Quiz	77
7	Folk show / Puppet shows/ Street plays	216
8	IPC workshop for MO & HW/ Advocacy meeting	280
9	Meeting with Zilla parishad Members	9
10	Orientation for NGO, SSG & SHG.	255
11	Health Mela/ Exhibitions/ haats Bazar	328
12	IPC Workshop at block level for Teachers, Govt. Officials & ASHA/ Patient provider interaction meetings	722
13	Publicity by Mega phone	1425

### **Institutionalization of DPMR activity with NRHM**

Disability Prevention & Medical Rehabilitation (DPMR) programme under NELP was launched in the entire country since 2007-08. The objective of DPMR programme is to provide disability care services to persons affected with disability/ deformity due to leprosy through General Health Care System.

Objectives: To increase the utilisation of DPMR services, an attempt has been taken to integrate DPMR activities with institutional set up, created under NRHM. The NRHM institutions like Village Health and Sanitation Committee (VHSC), untied funds, Rogi Kalyan Samiti (RKS) and District and State level- FMG with flexi fund of NRHM have been established to provide health care services to people at their doorstep. Integrating the activities of DPMR from village level to District level like identification of Persons Affected with Leprosy with disability at village level with involvement of VHSC, their referral to PHC by meeting travel cost from untied funds, procurement of prednisolone tabs for reactions/neuritis cases, MCR footwears, splints, dressing materials etc. have been identified as the activities of RKS by issuing financial guidelines including job descriptions, organising sensitisation meeting at different levels, capacity building of field level functionaries and paying field level supervisory visits. Supportive medicines distributed to the persons affected with Leprosy. During the year 2008-09, 392 Lepra reaction cases were treated, 1020 pairs of MCR footwears were distributed, 467 Self care kits were

provided and 61 Reconstructive Surgery Operations (RCS) were done.

During 2009-10, 449 Leprosy reaction cases were treated, 24 relapse cases were reported, 61 cases developed new disability after MDT, 1867 persons were provided with MCR footwear, 933 self care kits were distributed and 113 RCS operations were done.

There are 20 Leprosy Colonies in the State, 985 persons affected with leprosy are living in the colonies 331 pairs of MCR footwear were distributed, 368 ulcer cases are being treated, 667 were provided with disability certificates, 5 persons have undergone RCS and 663 persons are getting monthly pension.

#### **District Nucleus Team (DNT):-**

In all the 29 districts DNTs have been constituted. The staff under the leadership of the DLO are implementing the NLEP programme effectively. DNT is visiting the field and doing validation of cases. Supervision and monitoring is done effectively for the implementation of NLEP.

#### **Capacity Building:-**

Under the Capacity Building training has been arranged for the Medical Officers and also the Health care staff. Each district has trained 1 batch of Newly appointed Medical officers for 4 days, orientation training for the Medical Officers for 2 days and 3 days orientation training for the Health Workers.

#### **NGOs Service:-**

7 NGOs are working in the State, 3 in Bangalore city. Monthly review meeting of DLOs and NGOs of Bangalore city is being conducted regularly for the affective implementation of Urban Leprosy Eradication Programme in Bangalore city under NLEP. NGOs are conducting Surveillance activities, IEC activities and DPMR activities in the Urban slums of Bangalore city.

AIFO is co-ordinating with the State Leprosy Office. AIFO has conducted a workshop for the DNT team for 2 days to create awareness, early diagnosis and MDT, Prevention of Deformity (POD), enhancing DPMR activities, IEC activities validation of cases and Supervision monitoring of the NLEP programme. AIFO representative is attending the monthly NGOs meeting regularly at SLOs office. AIFO in co-ordination with the state office organised

2 days Decentralised Planning Workshop for the DLOs of the State. AIFO has assisted for preparing the State PIP for the year 2010-11. AIFO has supplied the Operational Guidelines of DPMR activities books to all the Primary Health Centres and the Secondary Level Health Care Hospitals.

### **Financial Management System**

- State Leprosy Society has been merged with the State Health & FW Society under NRHM.
- District Leprosy Society has been merged with the District Health & FW Society under NRHM.

### **Programme Review & Monitoring**

- The Programme is monitored routinely at District, State and Central Leprosy Division level through scrutiny of regular monthly reports.
- At the State Level Quarterly Review Meeting is being done regularly.
- The state level officers are visiting the districts and supervising the NLEP activities.
- DHO/DLOs are supervising and monitoring the NLEP activities at Taluk and PHC level.
- THOs are monitoring NLEP activities at PHC level.

### **Activity details along with budget for 2010-11**

<b>Sl. No.</b>	<b>Activities and approved PIP norms of expenditure</b>	<b>Amount Proposed (Rs. in Lakhs)</b>
<b>G I</b>	<b>Contractual Services</b>	
	<b>1. Epidemiologist /Surveillance Medical Officer @ Rs. 22,000/- p.m x 12 mths</b>	<b>2.64</b>
	<b>2. Budget &amp; Finance Officer (BFO) @ Rs. 15,000/- p.m x 12 months</b>	<b>1.80</b>
	<b>3. Administrative Assistant @ Rs. 7000/- p.m. x 12 months</b>	<b>0.84</b>
	<b>4. Data Entry Operator (DEO) @ Rs. 8000/- p.m. x 12 months</b>	<b>0.96</b>

<b>5. Driver for State office @ Rs. 4500 x 12 months</b>	<b>0.54</b>
<b>6. Drivers @ Rs. 4500/- p.m. x 12 months x 6 nos (NRHM guidelines)</b>	<b>3.24</b>
<b>7. TA/DA of the Drivers</b>	<b>1.44</b>
<b>8. Salary of contractual staff of state &amp; Districts if appointed</b>	<b>2.04</b>
<b>Total</b>	<b>13.50</b>

### **GI. Contractual Services**

During 2010-11 following categories of staff will be required to be provided to the State Leprosy Unit on contract basis for smooth functioning:

1. Epidemiologist /Surveillance Medical Officer @ Rs. 22,000/- p.m x 12 months according to GOI guidelines. SMO was appointed in the month of September 2008. In the agreement the remuneration was fixed at Rs. 22000/- per month.
2. Budget & Finance Officer (BFO) @ Rs. 15,000/- p.m x 12 months
3. Administrative Assistant @ Rs. 7000/- p.m. x 12 months
4. Data Entry Operator (DEO) @ Rs. 8000/- p.m. x 12 months
5. Drivers @ Rs. 4500/- p.m. x 12 months x 6 nos (NRHM guidelines) GOI has sanctioned 12 contractual drivers to the district and 1 to the Driver to SLO office. Only 6 drivers are working in the districts. Provision of TA/DA for drivers is proposed.

### **G .II Honorarium to ASHA workers**

<b>S. No</b>	<b>Activities and approved PIP norms of expenditure</b>	<b>Amount Proposed (Rs. in Lakhs)</b>
<b>G. II</b>	<b>Honorarium to ASHA workers</b>	<b>3</b>
	<b>Sensitisation to ASHAs</b>	<b>6</b>
	<b>Total</b>	<b>9</b>

### **G.2 Honorarium to ASHA workers**

A scheme to involve ASHAs under NRHM has been drawn up to bring from their villages for diagnosis at PHC and after diagnosis to follow up the patients for completion for their treatment. The ASHAs will be entitled to receive incentive as below:

- i) On confirmed diagnose of cases brought by them – Rs.100

ii) On completion of full course of treatment within specified time-

PB Leprosy case – Rs. 200/-

MB Leprosy Case – 400/-

In Karnataka 39195 ASHAs have been selected for training, 16140 ASHAs have been trained and are already working. The budget of 3 lakhs has been provided to give incentives to ASHAs at the rate of Rs.300 x 500= 150000 for PB cases and Rs. 500 x 300 = 150000 for MB cases, total for 800 cases.

<b>G. 3</b>	<b>Office Expenses &amp; Consumables</b>	
	<b>1. State Health &amp; FW Society, (Leprosy Division)</b>	<b>1.3</b>
	<b>2. District Health &amp; FW Society (Leprosy Division) (Rs. 32000 x 29 Districts)</b>	<b>8.7</b>
	<b>Total</b>	<b>10</b>

### **G. III Office Expenses & Consumables:**

For the functioning of the State Leprosy Office and the 29 District Leprosy Offices above budget is required for Office Expenditure like, Telephone charges, accessories of Fax, Computer, Xerox.

For the functioning of the State Leprosy Office and the 29 District Leprosy Offices above budget is required for Consumables like Stationary items.

<b>G.4</b>	<b>Capacity Building (Training)</b>	
	<b>1. 4 days training for newly appointed MOs (Rs. 39000 x 27 districts &amp; 55000 x 1 district (Gulbarga)0 for Kodagu</b>	<b>11.08</b>
	<b>2. 3 days training for newly appointed Health Worker (Rs. 14050 x 29 districts)</b>	<b>4.08</b>
	<b>3. 2 days refresher training to MOs (Rs. 16700 /batch x 29 districts.)</b>	<b>4.84</b>
	<b>Total</b>	<b>20.13</b>

## G. IV Capacity Building (Training)

Training has to remain as a continuous process, although the country has achieved elimination of leprosy as a public health problem yet there are 2 districts that have high endemic Districts of leprosy in the state. Further due to turn over of Medical Officers in the State the staff in the Primary Health Centre keep changing every year. The new entrants are needed to be trained regularly so that the services to be provided to the people. In addition to the new entrants the remaining medical officers required re-orientation training. Induction is needed for Health Supervisors (Male/Female, Health Workers, Lab. Tec & ASHAs).

Unit cost for conducting different courses for 30 persons have been worked out as above:-

<b>G.5</b>	<b>IEC (Behavioral Change Communication)</b>	
	<b>1. Mass Media (TV, Radio, Press) (Rs.18034 x 29 districts)</b>	<b>5.23</b>
	<b>2. Outdoor Media (Hoardings, Bus panel, Wall paintings, Posters, Rallies including Banners) Rs. 20300 x 29 districts.</b>	<b>5.89</b>
	<b>3. Rural Media (IPC group meetings, School IEC, Folk media Exhibitions &amp; Health Melas.) Rs.15000 x 29 districts</b>	<b>4.35</b>
	<b>4. Advocacy (Meetings with ZP, Mahila Mandals, NGOs etc) Rs. 4690 x 29 districts.</b>	<b>1.36</b>
	<b>5. Observation of Anti Leprosy month Jan. 2011 State Health FW Society, Leprosy Division Rs. 44000/ year.</b>	<b>0.40</b>
	<b>6. Observation of Anti - Leprosy Month-Jan. 2011 District Health &amp; FW Societies, Leprosy Division Rs.10000x29 districts.</b>	<b>2.90</b>
	<b>7. Special IEC &amp; Special Situational Activities Plan for Blocks having more NCDR &amp; PR (Rs60000 x 7districts)Rs67000x1district Gulbarga</b>	<b>4.87</b>
	<b>Total</b>	<b>25</b>

## G. V IEC (Behavioral Change Communication)

The priority areas and target groups to be attended to

1. Mass media: To a limited extent through local centers of TV, Radio and press in local languages.
2. Outdoor : Hoardings, Bus panels. Wall paintings, posters, Rallies including Banners.
3. Rural Media: IPC group meetings, School IEC, Folk media, Exhibitions and Health Meals.
4. Advocacy: Meetings with Zilla Parishad, Mahila Mandals, NGOs etc.
5. Observation of Anti-Leprosy month in the State.
6. Observation of Anti-Leprosy month in the Districts.
7. Special IEC & Special Situational Activities Plan for 8 districts (Chitradurga, Dharwad, Gadag, U.K, Bellary, Tumkur, Davangere and Gulbarga)

Interpersonal Communication (IPC) through the Health staff involving communities, panchayat leaders and NGO through advocacy workshop will remain the focused approach.

<b>G. 6</b>	<b>Vehicle Maintenance and Hiring</b>	
	<b>1. State Health &amp; FW Society, (Leprosy Division) @ Rs. 85000, / year x 2</b>	<b>1.7</b>
	<b>2. District Health &amp; FW Society (Leprosy Division) @ Rs. 70000 / year x 29 districts.</b>	<b>20.3</b>
	<b>Total</b>	<b>22</b>

#### **G. VI. Vehicle Maintenance and Hiring**

For the movement of the State Leprosy Officer and other officers of the State Leprosy Office and for the movement of the 29 District Leprosy Officers & Staff above Budget is required for the Vehicle Maintenance & Hiring of Vehicle:

<b>G.7</b>	<b>Disability Prevention and Medical Rehabilitation (DPMR)</b>	
	<b>1. MCR foot wear @ Rs. 250/pair x 120 pairs / dist. X 29 dist.Rs 30000/district</b>	<b>8.70</b>
	<b>2. Reconstructive Surgery (RCS )for Patients of BPL</b>	<b>4.00</b>

	<b>category of 29 districts conducting RCS operations in only 3 districts 1) Tumkur&amp; 2) Dharwad .</b>	
	<b>3. RCS allowances for new institutionsfor Bangalore urban district for conducting RCS operations</b>	<b>3.00</b>
	<b>4. Splints, Crutches, Spectacles, Self care Kits &amp; any other Aids required for Leprosy patients Rs. 13000/ X 28 Districts&amp;Rs 10000 for kodagu district</b>	<b>3.74</b>
	<b>5. DPMR activities at state level</b>	<b>3.06</b>
	<b>Total</b>	<b>22.50</b>

### **G.VII Disability Prevention and Medical Rehabilitation (DPMR)**

For Grade I disability cases MCR Footwears are provided free of cost to the LAPs as above.

For Grade II disabilities reconstructive surgeries (RCS) being done in 2NGO centers in the State

1. SVIRHC Pavgada
  2. HHS Hospital for handicapped Hubli
- RCS operations are also being conducted by the Govt. hospitals in the state.

Incentives to the patients undergone RCS will be given as mentioned in the above Budget

Splints, Crutches, Spectacles, Self care Kits & any other Aids required for LAPs will be provided as per the above budget

<b>G. 8</b>	<b>Materials and Supplies Drugs</b>	
	<b>1. Supportive Drugs Rs.25000/- per year x 29 Districts and</b>	<b>7.25</b>
	<b>2. Lab reagents &amp; equipments 10000/year X4 Districts- Ban (U), Mysore, Gulbarga &amp; Belgaum</b>	<b>0.40</b>
	<b>3. Printing cost @ Rs. 15000/- yr. Dist. X 29 dist.</b>	<b>4.35</b>
	<b>Total</b>	<b>12</b>

### **G. VIII Materials and Supplies Drugs**

Besides the MDT the Anti leprosy drugs the other drugs materials are essential to treat the following conditions:-

1. Reactions.
2. Disabilities
3. Eye Complications.
4. Commonly associated general conditions.

For each district Rs.25000/- budget is provided for the purchase of the Drugs /Materials needed other than the MDT drugs, the Drugs/Material to be procure as per the Karnataka Transparency act by the District Health & FW Society.

The Budget is also provided for all the 4 Districts for the procurement of Laboratory reagents & equipments to do the investigation of Leprosy cases. Budget for the 29 Districts for the printing of required forms & registers is provided

<b>G.9</b>	<b>Urban Leprosy Strategy</b>	
	<b>1. Mega city I. - (Population more than 25 lakhs) Bangalore (U) (Rs.280000 x 1)</b>	<b>2.80</b>
	<b>2. Medium City I.(Population between 5 and 25 lakhs)- Hubli Dharwad, &amp; Mysore &amp; Gulabarga Rs. 120000 x3 districts.</b>	<b>3.60</b>
	<b>3. Townships (Population between 1 &amp; 5 lakhs) – 22cities- at Rs.57000/ city &amp;Rs.56000 for Udupi</b>	<b>13.10</b>
	<b>Total</b>	<b>19.5</b>

#### **G. IX. Urban Leprosy Strategy**

Since the Urban areas do not have the Primary Health Centre like infrastructure and there are multiple organizations providing Health services in these localities, Govt. of India has sanctioned special urban leprosy elimination programme under NLEP. The programme started in 2005.

#### **Additional funds provided by Govt. of India for urban areas;**

- 1) Supportive Medicines
- 2) MDT Delivery services and follow up.
- 3) Monitoring, Supervision & Coordination.
- 4) Training.
- 5) IEC activities.

There are 23 townships with population of 1 to 5 lakhs, 3 cities with population between 5 & 25 lakhs & there is only one mega city with population of more than 25 lakhs.

<b>G.10</b>	<b>NGO Survey Education Treatment (SET) Scheme</b>	
	<b>1. Amount for NGOs under SET Scheme</b>	<b>4.5</b>
	<b>Total</b>	<b>4.5</b>

## **G.X NGO Survey Education Treatment (SET) Scheme**

When the prevalence rate was high there were survey education and treatment (SET) centers in the state. After the prevalence rate has come down according to GOI guidelines all the SET centers are closed. GOI has given permission to NGOs to continue the center. The above Budget will be utilized for the NGOs running SET centers.

<b>G-11</b>	<b>Supervision, Monitoring &amp; review</b>	
	<b>1. State level quarterly DLOs review meeting</b>	<b>1.00</b>
	<b>2. TA /DA to Contractual staff (BFO , SMO &amp; Drivers)</b>	<b>1.00</b>
	<b>Total</b>	<b>2.00</b>

## **G-XI Supervision, Monitoring & review**

The NLEP programme will mainly provide services through the general Health Service infrastructure with supervisory support from the District nucleus staff level Officers. Contract staff like surveillance Medical Officer, BFO and Drivers will have to be paid from the programme budget.

Every 3 months State level DLOs review meeting will be conducted by the State Officers the above Budget is provided for the review meeting.

<b>G.12</b>	<b>Cash Assistance</b>	
	<b>TA/DA for SLO office staff</b>	<b>6.00</b>
	<b>TA/DA for District Nucleus Team at DLO officers.12000x28districts &amp;Rs 12800 for Gulbarga district</b>	<b>3.60</b>
	<b>IEC</b>	<b>0.40</b>
	<b>Total</b>	<b>10.00</b>
	<b>Grand Total</b>	<b>170.00</b>

## **G.XII Cash Assistance**

The above Budget is provided for TA/DA for District Nucleus Team at DLOs office, IEC at the State level, TA/DA for SLO office staff.

**Karnataka State NLEP Programme Implementation Plan (PIP) for 2010-11**

<b>Sl. No.</b>	<b>Activities and approved PIP norms of expenditure</b>	<b>Amount Proposed (Rs. in Lakhs)</b>
<b>G I</b>	<b>Contractual Services</b>	
	<b>1. Epidemiologist /Surveillance Medical Officer @ Rs. 22,000/- p.m x 12 mths</b>	<b>2.64</b>
	<b>2. Budget &amp; Finance Officer (BFO) @ Rs. 15,000/- p.m x 12 months</b>	<b>1.80</b>
	<b>3. Administrative Assistant @ Rs. 7000/- p.m. x 12 months</b>	<b>0.84</b>
	<b>4. Data Entry Operator (DEO) @ Rs. 8000/- p.m. x 12 months</b>	<b>0.96</b>
	<b>5. Driver for State office @ Rs. 4500 x 12 months</b>	<b>0.54</b>
	<b>6. Drivers @ Rs. 4500/- p.m. x 12 months x 6 nos (NRHM guidelines)</b>	<b>3.24</b>
	<b>7. TA/DA of the Drivers</b>	<b>1.44</b>
	<b>8. Salary of contractual staff of state &amp; Districts if appointed</b>	<b>2.04</b>
	<b>Total</b>	<b>13.50</b>
<b>G. II</b>	<b>Honorarium to ASHA workers</b>	<b>3</b>
	<b>Sensitisation to ASHAs</b>	<b>6</b>
	<b>Total</b>	<b>9</b>
<b>G. III</b>	<b>Office Expenses &amp; Consumables</b>	
	<b>1. State Health &amp; FW Society, (Leprosy Division)</b>	<b>1.3</b>
	<b>2. District Health &amp; FW Society (Leprosy Division) (Rs. 32000 x 29 Districts)</b>	<b>8.7</b>
	<b>Total</b>	<b>10</b>
<b>G. IV</b>	<b>Capacity Building (Training)</b>	
	<b>1. 4 days training for newly appointed MOs (Rs. 39000 x 27 districts &amp; 55000 x 1 district (Gulbarga)0 for Kodagu</b>	<b>11.08</b>

	<b>2. 3 days training for newly appointed Health Worker (Rs. 14050 x 29 districts)</b>	<b>4.08</b>
	<b>3. 2 days refresher training to MOs (Rs. 16700 /batch x 29 districts.)</b>	<b>4.84</b>
	<b>Total</b>	<b>20.13</b>
<b>G. V</b>	<b>IEC (Behavioral Changes Communication)</b>	
	<b>1. Mass Media (TV, Radio, Press) (Rs.18034 x 29 districts)</b>	<b>5.23</b>
	<b>2. Outdoor Media (Hoardings, Bus panel, Wall paintings, Posters, Rallies including Banners) Rs. 20300 x 29 districts.</b>	<b>5.89</b>
	<b>3. Rural Media (IPC group meetings, School IEC, Folk media Exhibitions &amp; Health Melas.) Rs.15000 x 29 districts</b>	<b>4.35</b>
	<b>IEC (Behavioral Change Communication)</b>	<b>1.36</b>
	<b>5. Observation of Anti Leprosy month Jan. 2011 State Health FW Society, Leprosy Division Rs. 44000/ year.</b>	<b>0.40</b>
	<b>6. Observation of Anti - Leprosy Month-Jan. 2011 District Health &amp; FW Societies, Leprosy Division Rs.10000x29 districts.</b>	<b>2.90</b>
	<b>7. Special IEC &amp; Special Situational Activities Plan for Blocks having more NCDR &amp; PR (Rs60000 x 7districts)Rs67000x1district Gulbarga</b>	<b>4.87</b>
	<b>Total</b>	<b>25</b>
<b>G. VI</b>	<b>Vehicle Maintenance and Hiring</b>	
	<b>1. State Health &amp; FW Society, (Leprosy Division) @ Rs. 85000, / year x 2</b>	<b>1.7</b>
	<b>2. District Health &amp; FW Society (Leprosy Division) @ Rs. 70000 / year x 29 districts.</b>	<b>20.3</b>
	<b>Total</b>	<b>22</b>
<b>G.VII</b>	<b>Disability Prevention and Medical Rehabilitation (DPMR)</b>	
	<b>1. MCR foot wear @ Rs. 250/pair x 120 pairs / dist. X 29 dist.Rs 30000/district</b>	<b>8.70</b>

	<b>2 . Reconstructive Surgery (RCS )for Patients of BPL category of 29 districts conducting RCS operations in only 3 districts 1) Tumkur&amp; 2) Dharwad .</b>	<b>4.00</b>
	<b>3. RCS allowances for new institutionsfor Bangalore urban district for conducting RCS operations</b>	<b>3.00</b>
	<b>4. Splints, Crutches, Spectacles, Self care Kits &amp; any other Aids required for Leprosy patients Rs. 13000/ X 28 Districts&amp;Rs 10000 for kodagu district</b>	<b>3.74</b>
	<b>5. DPMR activities at state level</b>	<b>3.06</b>
	<b>Total</b>	<b>22.50</b>
<b>G. VIII</b>	<b>Materials and Supplies Drugs</b>	
	<b>1. Supportive Drugs Rs.25000/- per year x 29 Districts and</b>	<b>7.25</b>
	<b>2. Lab reagents &amp; equipments 10000/year X4 Districts- Ban (U), Mysore, Gulbarga &amp; Belgaum</b>	<b>0.40</b>
	<b>3. Printing cost @ Rs. 15000/- yr. Dist. X 29 dist.</b>	<b>4.35</b>
	<b>Total</b>	<b>12</b>
<b>G. IX</b>	<b>Urban Leprosy Strategy</b>	
	<b>1. Mega city I. - (Population more than 25 lakhs) Bangalore (U) (Rs.280000 x 1)</b>	<b>2.80</b>
	<b>2. Medium City I.(Population between 5 and 25 lakhs)- Hubli Dharwad, &amp; Mysore &amp; Gulabarga Rs. 120000 x3 districts.</b>	<b>3.60</b>
	<b>3. Townships (Population between 1 &amp; 5 lakhs) – 22cities- at Rs.57000/ city &amp;Rs.56000 for Udupi</b>	<b>13.10</b>
	<b>Total</b>	<b>19.5</b>
<b>G. XI</b>	<b>NGO Survey Education Treatment (SET) Scheme</b>	
	<b>1. Amount for NGOs under SET Scheme</b>	<b>4.5</b>
	<b>Total</b>	<b>4.5</b>
<b>G</b>	<b>Supervision, Monitoring &amp; review</b>	

<b>XII</b>		
	<b>1. State level quarterly DLOs review meeting</b>	<b>1.00</b>
	<b>2. TA /DA to Contractual staff (BFO , SMO &amp; Drivers)</b>	<b>1.00</b>
	<b>Total</b>	<b>2.00</b>
<b>G.12</b>	<b>Cash Assistance</b>	
	<b>TA/DA for SLO office staff</b>	<b>6.00</b>
	<b>TA/DA for District Nucleus Team at DLO officers.12000x28districts &amp;Rs 12800 for Gulbarga district</b>	<b>3.60</b>
	<b>IEC</b>	<b>0.40</b>
	<b>Total</b>	<b>10.00</b>
	<b>Grand Total</b>	<b>170.00</b>

## CHAPTER-29

### NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS

#### Objective:

**315.** The Objective is to provide improved eye care services to the people and also to ensure that no citizen goes blind or remains so needlessly by reasonable deployment of skill and resources, his eye sight could be prevented from deteriorating and if already lost could be restored through appropriate interventions.

**316.** The population of Karnataka is 6.05 crores. The incidence rate in Karnataka is 1%. Approximately 6.05 lakhs people are affected by blindness. For the effective implementation of National Programme for Control of Blindness in Karnataka State Health and F.W. Society (**Blindness Control Division**) is functioning as an organ of NRHM at State level with the following personnel in place.

- Joint Director (Ophthalmology)/ State Programme Officer – NPCB
- Manager
- Accounts Assistant
- Stenographer Grade-1
- Computer Operator
- Driver
- Group 'D'

**317.** The State Programme Officer will implement and monitor the programme through a network of District Programme Managers (Blindness Control Division) at District level. To ensure implementation of the National Programme for Control of Blindness effectively at District level, the District Health & F.W. Society (R.) (Blindness Control Division) has been created under NRHM which will implement the Blindness control activities through Government and Voluntary Sectors affiliated to NPCB through MoU. The Voluntary Sectors are provided incentives through Grant-in-Aid as per the package approved under

11<sup>th</sup> Five year plan for the Cataract Surgeries. The following are the functions of DH&FWS(BCD):

- a) Periodically assess the magnitude of the problems of blindness in the District, to monitor and to report to the SPO.
- b) To motivate voluntary organizations affiliated to NPCB in arranging Eye Camps.
- c) To provide free spectacles to the poor patients who under go cataract surgery and also to the school children identified with Refractive Error under School Eye Screening Programme.
- d) To release Grant in Aid to voluntary organizations affiliated to NPCB for free eye camps.
- e) Maintenance of Village Blind Register and periodical updations.
- f) Maintenance of proper accounts and furnishing UCs and SOE and necessary reports to KSH&FWS (BCD) from time to time.

### **NEW SCHEMES:**

**318.** Govt. of India under the 11<sup>th</sup> Five year Plan has initiated new interventions like Diabetic Retinopathy, Glaucoma management, Laser Technique, Corneal Transplantation, Vitreo Retinal Surgery, Treatment of Childhood Blindness etc., in order to provide improved eye care services to the people through NPCB. The Govt. of India has further enhanced the Financial assistance for Commodity Assistance to RIO, Dept. of Ophthalmology of Medical Colleges, District Hospitals, Taluk Hospitals and Vision Centres. The Recurring Assistance for Eye Ball collection and Non recurring GIA to Eye care Units and Eye Banks in NGO sector has also been enhanced.

### **Vision Centres:**

**319.** Out of Targeted 30 Vision Centres at PHC level for the year 2009-10, 16 Vision Centres have been developed and the remaining 14 are being developed since the budget from GOI has been received now. The amount has been released to develop remaining 14 centres.

<b>Sl. No.</b>	<b>Name of the Districts</b>	<b>No. of Vision Centres developed during 2009-10</b>
1.	Bangalore (Urban)	1
2.	Bangalore (Rural)	1
3.	Ramanagaram	1
4.	Chitradurga	1
5.	Chikkaballapur	1
6.	Shimoga	1
7.	Mysore	1
8.	Kodagu	1
9.	Dharwad	1
10.	Bellary	1
11.	Haveri	1
12.	Gulbarga	1
13.	Uttara Kannada (Karwar)	1
14.	Bijapur	1
15.	Bagalkote	1
16.	Udupi	1
<b>Total</b>		<b>16</b>

**During the year 2010-11, 30 more vision centres will be formed**

**To Districts Hospitals Karwar & Gadag have been taken for development. Two more districts will be taken during 2010-11**

**DEVELOPMENT OF EYE CARE UNIT IN BACKWARD AREA:**

**320.** To better Eye Care facility under Extension of Eye Care Unit in under served area the West Lions Eye Hospital at Kollegal has been provided Non-Recurring Grant-in-Aid so as to provide improved Eye Care facility including Cataract Surgeries as this a backward area. One more eye care unit will be developed during the year 2010-11

**DEVELOPMENT OF EYE BANK IN BACKWARD AREA:**

**321.** To improve the Eye Bank infrastructure in the backward areas to help increase Eye Ball Collection, Rs. 10 lakhs Non-Recurring Grant-in-Aid has been provided to B.V.V Sangha

Medical College Eye Bank, Bagalkote. One more Eye bank, shraddha Eye bank is going to be upgraded this year one more eye bank infrastructure will be developed during the year 2010-11.

### **DEVELOPMENT OF EYE CARE INFRASTRUCTURE OF MEDICAL COLLEGES:**

**322.** Under this scheme Rs.40 lakhs each (total Rs. 120 lakhs) has been released to -

1. Mysore Medical College, Mysore
2. Vijayanagara Institute of Medical Sciences, Bellary
3. Karnataka Institute of Medical Sciences, Hubli

for development of Ophthalmology Department of these Medical Colleges.

One more Govt Medical College will be developed during this year.

One more will be developed during the year 2010-11

### **UPGRADATION OF DISTRICT MOBILE OPHTHALMIC UNITS**

**323.** 31 District Mobile Ophthalmic units are functioning in the State to provide creative, promotive and surgical facilities to rural and tribal communities by adopting camp approach with the following staff:

- Ophthalmic Eye surgeon
- Block Health Educator
- Staff Nurse
- Paramedical Ophthalmic Assistant
- Driver
- Group 'D'

### **UPGRADATION OF PRIMARY HEALTH CENTRES:**

**324.** 437 PMOAs are working in various Hospitals and applications for appointment of 68 more PMOAs are under process. Two PMOAs have been appointed on contract basis as per the approval of the PIP 2009-10 in Karwar (U.K) District to improve the delivery of

Eye Care services since many posts of PMOAs are vacant. Six more PMOAs will be selected during the year 2010-11 on contract basis.

### **ADVANCED EYE SURGERY TRAINING**

**325.** To provide improved Eye care Services 6 Eye Surgeons working in Govt. Hospitals including Medical Colleges have been trained in various advanced Eye surgery techniques under NPCB by Govt. of India. 2 days Cataract Management Protocol Workshop for Ophthalmic Surgeons and District Programme Managers (Blindness Control Division) was conducted at Sankara Eye Hospital in association with Sight Savers International, Mumbai in order to standardize the Protocol on Cataract Surgeries to achieve qualitative improvement so as to reduce post operative infections and Endophthalmitis. No training activities will be taken up during the year 2010-11.

**326.** The PHC and CHCs are the service delivery points for Eye Care to the people. Hence in order to ensure better and improved Eye care services at these institutions, 240 Medical Officers working at PHC / CHC level have been trained on Community Ophthalmology practice at Primary care level through State Institute of Health and Family Welfare under NPCB. No training activities will be taken during this year. The training programs not done during the year 2009-10 will be completed during this year 2010-11.

### **SCHOOL EYE SCREENING PROGRAMME:**

**327.** Screening of School children for refractive error is one of the important activities of the National Programme for Control of Blindness. Every year, middle school children are primarily screened by the trained teachers and then by Para Medical Ophthalmic Assistants, and poor students who have refractive errors, are distributed free spectacles by District Health & F.W. Society (Blindness Control Division). During the current year Rs.30.35 lakhs has been released to the District Health & F.W. Society (Blindness Control Division) for undertaking School Eye Screening Programme including training of the Teachers for Primary Screening of School Children.

**Table-55**

**PHYSICAL TARGET & ACHIEVEMENTS UNDER N.P.C.B. for  
Cataract Operations**

<b>Year</b>	<b>Target</b>	<b>Achievement</b>	<b>%</b>
2007-08	3,50,000	3,14,937	90.00
2008-09	4,00,000	3,84,447	96.11
2009-10	4,00,000	2,26,400 (upto Nov. '09)	64.88

**Table-56**

**SCHOOL EYE SCREENING PROGRAMME**

<b>Year</b>	<b>No. of School Children Screened</b>			<b>No. of Children Detected with Refractive Error</b>			<b>No. of Free Specs provided</b>		
	<b>Target</b>	<b>Achvt.</b>	<b>%</b>	<b>Target</b>	<b>Achvt.</b>	<b>%</b>	<b>Target</b>	<b>Achvt.</b>	<b>%</b>
2007-08	1000000	1742413	174	70000	168367	241	21000	17257	82
2008-09	952381	2051441	215	66667	88801	133	20000	20677	103
2009-10	210000	881457 (upto Nov. '09)	420	12600	12406 (upto Nov. '09)	48.8%	3780	4055 (upto Nov. '09)	129.92

**Table-57**

**EYE BALLS COLLECTION UNDER NPCB**

<b>Year</b>	<b>Target</b>	<b>Achievement</b>	<b>%</b>
2007-08	5,000	2,280	45.60
2008-09	5,500	2,407	43.76
2009-10	5,000	3,824 (upto Dec 09)	76.48

**Table-58**

**Grant in Aid released to Karnataka State Health & F.W Society  
(Blindness Control Division) from Govt. of India:**

Year	Released	Expenditure
2007-08	784.00	861.47
2008-09	1041.66	1077.00
2009-10	1064.41	612.43 up to Dec'09

**Table-59**

**BUDGET UNDER NPCB FOR FY - 2010-11**

Sl. No.	Programme/Activity	Unit of measure	UNIT COST Rs. in Lakhs	No. of UNITS Proposed	Amount (Rs.in lakhs)
H	<b>NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS(NPCB)</b>				
H.1	<b>Cataract Surgeries</b>				
H.1.1	GIA to NGOs for Cataract Surgeries as per package approved under 11th plan	per surgery	0.00750	220,000	590.60
H.1.2	Recurring GIA to Private Practitioners for Free Cataract surgeries ( <b>New Initiative of GOI as per Table</b> )	per surgery	0.00750	10,000	<b>75.00</b>
H.1.3	Incentive to ASHA to motivate patients for Cataract operations in low performing blocks, and Districts.	per case	0.00175	4,710	<b>8.24</b>
H2	<b>Contractual Appointments:</b>				
H.2.1	Honorarium to DPM(BCD) @ Rs.2000/- PM x 12 months	per District	0.24000	29	<b>6.96</b>
H.2.2	Operational Cost for DH and F.W.Society(BCD) @ Rs.150,000/- per annum per District ( Remuneration for Part time AA, Drivers, Office expenses, Stationery, Postage / Courier services, meetings, TA/DA etc	per District	1.50000	29	<b>43.50</b>
H.2.3	Appointment of Ophthalmic Surgeons on contract basis for 2 Districts @ Rs.25,000/- per OS per month,( <b>New initiative of GOI to ensure adequate manpower</b> )	per District	3.00	2	<b>6.00</b>

H.2.4	Appointment of PMOAs on contract basis for - 6 PHCs or/ Vision Centres of Districts where PMOAs posts are vacant @ Rs.8,000/- each PMOA per month, ( <b>New initiative of GOI to ensure adequate manpower</b> )	per District	0.96	6	<b>5.76</b>
H.2.5	Eye Donation Councillors for Eye Banks in Govt/ Voluntary Sector @ Rs.10000/- PM for each Councillors - ( <b>New initiative of GOI to ensure adequate manpower</b> )	per Eye Bank	1.20		<b>0.00</b>
H.2.6	<b>Recurring Grant in Aid for Management of KSH and F.W. Society (Blindness Control Division):</b> To meet Remuneration of contractual Staff, TA/DA, Honorarium to SPO(NPCB), Quarterly Review Meetings, Hiring of Vehicles /POL, , Maintenance of Office equipments etc.,AMC, Contingencies, & Operational expenses.	State level			<b>20.00</b>
H.3	<b>IEC activities:</b>				
H.3.1	IEC activities by Dist.H and F.W.Society(BCD) @ Rs.2,00,000/- per district for WSD, E.D.Fortnight and other occasions	per District	2.00	29	<b>58.00</b>
H.3.2	<b>IEC activity:</b> Printing and supply of Hoardings, Pamphlets, Posters, Calendars, Advertisements, TV /Cable, AIR, Newspapers, Awareness on Eye Donation among the public to motivate and increase eye ball collection required for Keratoplasty, WSD, EDFN 2010	State level			<b>30.00</b>
H.4	<b>Training Activities:</b>	-			
H.4.1	Training activities by DH and F.W.Society(BCD) @ Rs.25000/- per district ASHA /Anganwadi under NPCB	per District	0.25000		<b>0.00</b>

H.4.2	<b>Training activity at State Level :</b> Training of MOs CHC/PHC , Staff Nurses, PMOAs including manuals	State level			<b>0.00</b>
H.5	POL and maintenance of Vehicles (including hiring of vehicles for camps)	per District	0.55000		<b>15.95</b>
H..6	Schemes for Blind Schools: To provide visual aids to Two Blind schools in Karnataka to provide support for rehabilitation of incurably blind.	per Blind School	1.00000	2	<b>2.00</b>
H.7	<b>Strengthening of Medical Colleges: Non recurring assistance</b> @ Rs.40 lakhs for procurement of Ophthalmic Equipment as commodity assistance for development of Paediatric Eye Unit / Low vision unit / Retina Units, Audio visual aids (As per annexure III A of GOI).	per Medical college	40.00	1	<b>40.00</b>
H.8	<b>Strengthening of District Hospitals: Non recurring assistance</b> @ Rs. 20 lakhs for procurement of Ophthalmic Equipment to improve eye care facility.(As per annexure III B of GOI).	pre District Hospital	20.00	2	<b>40.00</b>
H.9	<b>Strengthening of Taluk Hospitals: Non recurring assistance</b> @ Rs. 5 lakhs for procurement of Ophthalmic Equipment to improve eye care facility.(As per annexure III B of GOI).	per Taluk Hospital	5.00	5	<b>25.00</b>
H.10	<b>School Eye Screening</b>				
H.10.1	<b>a) School Eye Screening</b> @ Rs.1,25,000/- each dist for Teachers Training and 20000 spectacles for School Children @ Rs.200/- per child.	per District	1.25		<b>76.25</b>
H.11	<b>New initiative :</b>				
H.11.1	Glaucoma, Diabetic Retinopathy, Laser Technique, Corneal Transplantation Childhood Blindness, Squint Surgery, @ Rs.1000/- per case treated - 1000 cases for	per case	0.01000	1,000	<b>10.00</b>

	Karnataka based on all India Target of 2 lakh worth Drugs to be given to the patient.				
	Computer with Accessories	Districts/state	1.00	31	<b>31.00</b>
H.11.2	Maintenance of Non- Recurring Assistance (Ophthalmic Equipments) through AMC 3 units @ Rs.5 lakhs per unit.	per unit	5.00	1	<b>5.00</b>
H.11.4	<b>Eye Banking activities:</b>				
H.11.5	<b>Recurring Assistance</b> for Eye Banks @ Rs.1,500/- as Incentive per pair of Eye Balls collected to boost eye ball collection.	per pair of Eye Balls	0.015	3000	<b>45.00</b>
H.11.6	<b>Recurring Assistance</b> for Eye Donation Centre @ Rs.1,000/- as Incentive per pair of Eye Balls collected to boost eye ball collection.	per pair of Eye Balls	0.010	500	<b>5.00</b>
H.11.7	<b>Eye Bank</b> - Development of Eye Banks in Govt. / NGO Sector to get adequate tissue for Corneal Transplantation to facilitate treatment of Corneal Blindness @ Rs.15 lakhs per Eye Bank.	per Eye Bank	15.00	2	<b>30.00</b>
H.11.8	<b>Eye donation centre</b> - Development of Eye donation centre affiliated to registered eye banks under HOTA in Govt. / NGO Sector to get adequate tissue for Corneal Transplantation to facilitate treatment of Corneal Blindness	per EDC	1.00	5	<b>0.00</b>
H.11.9	<b>Extension of Eyecare unit:</b> - in NGO sector in the underserved Area/Tribal Areas to provide free and subsidised eye care services for underserved affected population in Rural / Tribal/ Underserved areas @ Rs.30 lakhs per Unit to expand, upgrade and to develop capacity for sustainable eye care delivery in Voluntary Sector	per Eye care unit	30.00	1	<b>30.00</b>
H.11.10	<b>Vision Centre</b> - Non Recurring assistance of Rs.50000/- for	per Vision Centre	0.50	30	<b>15.00</b>

	basic Ophthalmic equipments for Strengthening of Vision centres at PHC level in Govt./ NGO Sector (As per annexure - III E of GOI)				
H.11.11	Salary component of Joint Director (Ophth) + personal staff + Staff nurse, PMOAS, Group D and Driver working in District Units				
H.12	Procurement of IOLs for performing Cataract Surgeries	per piece	0.001	50,000	<b>50.00</b>
H.12.1	Operating Microscope	per piece	2.50	5.00	<b>12.50</b>
H.12.2	Cataract Surgery set for SICS	per piece	0.10	100	<b>10.00</b>
H.12.3	Disposable blades for Small Incision Cataract Surgeries	per piece	0.001	10,000	<b>10.00</b>
<b>TOTAL</b>					<b>1296.76</b>

## CHAPTER-30

### REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME

In Karnataka State REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME (RNTCP) implemented from 1998 in a phased manner and the entire state was covered by August 2004. RNTCP is implemented with the following objectives.

1. To achieve and maintain a cure rate of at least 85% among newly detected infectious TB Cases (New smear Positive).
2. To achieve and maintain the detection of at least 70% of such cases (NSP) in the population.

Currently RNTCP is implemented in the state in all the 30 districts and also at Bangalore City. Thus there are 31 RNTCP districts in Karnataka state. There are 125 Tuberculosis units (TU) and 644 Designated Microscopic centers (DMCs) functioning in the State. One TB unit and 16 DMCs are in NGO operated hospitals and 24 DMCs are at Private sector hospitals. For the convenience of the TB patients nearly 40000 DOTs centers have been established and made functional in the state. RNTCP state drugs stores is operationalized for effective drug management under RNTCP. Of the 31 Districts One Newly formed District at Yadgiri, which is formed by bifurcating Gulburga District, the DTC will be established and made functional in the 2<sup>nd</sup> Quarter of 2010.

All the medical Colleges (Govt. and Private) are participating in RNTCP as DMC cum DOTs centers. The service of one TB-HV and one LT is being provided to all these institutions under RNTCP. In addition one Medical Officer each is also provided to 17 medical colleges based on the need and contribution to RNTCP.

The performance of RNTCP during the last 4quarters i.e from October 2008 to September 2009 a total of 66710 TB patients were registered and started RNTCP DOTs treatment with a annualized case detection rate of 115 per Lakh population per year. During the same year 25995 new smear positive cases were initiated on DOTs treatment with a NSP case detection rate of 45 per lakh population against a minimum bench mark of 53. Cure rate amongst NSP cases

registered during the corresponding previous 4 quarters is 78% against the minimum bench mark of 85%.

To improve the performance of RNTCP in the state the following priority areas are identified and planned for improvement in the next financial year.

1. Improve NSP and total case detection rates under RNTCP to the minimum bench mark.
2. Improve the cure rates by intensifying efforts to reduce defaults and death rates and increase the examination of follow up sputum.
3. Involvement of all medical offices and Health Department staff in referral of chest symptomatic, in case holding, in defaulter retrieval action and follow up sputum exams and in active supervision in the field.
4. Effective implementation of TBHIV collaborative activities including strict implementation of intensified TB HIV package of services
5. Establishment of Intermediate Reference Laboratory (IRL), with further strengthening of STDC and hasten the process of DOTs Plus services management of MDR TB cases by July 2010.
6. Strengthening of involvement of medical colleges, NGO, private sector and other sector hospitals.

RNTCP district of Bijapur, Bagalkot, Bidar, Gulburga, Ramanagara, BBMP, Bangalore Rural, Belgaum, Uttara Kannada ,and Bellary are taken up as Priority Districts for supervision and monitoring by the State during the next Financial year.

The Action Plan for the year 1<sup>st</sup> April 2010 to 31<sup>st</sup> March 2011 contains the following 4 sections.

Section A :- General Information about the state including the performance in key indicators.

Section B :- Priority areas at the state level for achieving the objectives planned under priority districts for Supervision and monitoring by the state during the next Financial year.

Section C :- Consolidated plan for Performance and Expenditure under each head including estimates submitted by all the districts and requirements at the state level.

Section D :- Summery of the proposed Budget for the year 2010-11 of the state.

**Objectives:**

1. To achieve and maintain a cure rate of at least 85% among
2. newly detected infectious (new sputum smear positive) cases, and
3. To achieve and maintain detection of at least 70% of such cases in the population

**Section-A – General Information about the State**

1	State Population (in lakh) <i>please give projected population for next year</i>	58606000
2	Number of districts in the State	30 +1(BBMP)
3	Urban population	14794915
4	Tribal population	1935884
5	Hilly population	2038725
6	Any other known groups of special population for specific interventions (e.g. nomadic, migrant, industrial workers, urban slums, etc.)	5892421

(These population statistics may be obtained from Census data /State Statistical Dept/ District plans)

*No. of districts without DTC: One*

No. of districts that submitted annual action plans, which have been consolidated in this state plan:  
30+1Bangalore City (BBMP)

**Organization of services in the state:**

S. No.	Name of the District	Projected Population (in Lakhs)	Number of TUs of each type		No. of DMCs of each type in the district		
			Govt	NGO	Public Sector*	NGO	Private Sector^
1	BAGALKOT	1836212	4	0	18	1	1
2	BANGALORE CITY	4636900	9	0	38	5	7
3	BANGALORE RURAL	920011	2	0	11	0	0
4	BANGALORE URBAN	2612572	5	0	25	0	2
5	BELGAUM	4675752	9	0	41	3	1
6	BELLARY	2250757	5	0	23	0	0
7	BIDAR	1668555	3	0	16	0	0
8	BIJAPUR	2010284	4	0	18	0	2
9	CHAMARAJANAGAR	1071649	3	0	13	1	0
10	CHIKKABALLAPUR	1266428	3	0	13	0	0
11	CHIKMAGALUR	1265946	4	0	19	1	0
12	CHITRADURGA	1678394	3	0	16	0	1
13	DAKSHINA KANNADA	2107572	5	0	23	0	6
14	DAVANAGERE	1988979	4	0	23	0	0
15	DHARWAD	1782380	4	0	20	0	1
16	GADAG	1080184	2	0	12	0	0
17	GULBARGA	2401818	5	0	22	0	0
18	HASSAN	1912992	4	0	17	0	0
19	HAVERI	1597969	3	0	15	0	0
20	KODAGU	606045	3	0	10	1	0
21	KOLAR	1537965	3	0	14	0	1
22	KOPPAL	1326394	3	0	13	0	0
23	MANDYA	1957889	4	0	23	1	1
24	MYSORE	2917201	6	0	30	1	1
25	RAICHUR	1831744	4	0	18	1	1
26	RAMANAGARA	1166459	2	0	12	0	0
27	SHIMOGA	1822168	4	0	19	0	2
28	TUMKUR	2866751	5	1	27	1	0
29	UDUPI	1233039	3	0	18	0	0
30	UTTARA KANNADA	1503992	4	0	16	2	0
31	YADGIRI	1071000	2	0	16	0	0
	<b>Total</b>	<b>58606000</b>	<b>124</b>	<b>1</b>	<b>599</b>	<b>18</b>	<b>27</b>

Name of the District (also indicate if it is notified hilly or tribal district)	Total number of patients put on treatment*	Annualised total case detection rate (per lakh pop.)	No of new smear positive cases put on treatment *	Annualised New smear positive case detection rate (per lakh pop)	Cure rate for cases detected in the last 4 corresponding quarters	Plan for the next year		Proportion of TB patients tested for HIV	No. of MDR TB suspects identified and subjects to C/DST of sputum	No. of MDR TB cases diagnosed & put on treatment
						Annualized NSP case detection rate	Cure rate			
BAGALKOT	2109	116	840	46	71%	53	85	83%	0	0
BANGALORE CITY	5837	127	1837	40	74%	53	85	64%	0	0
BANGALORE RURAL	1087	120	450	50	78%	53	85	81%	0	0
BANGALORE URBAN	3796	147	1323	51	80%	53	85	60%	0	0
BELGAUM	4970	107	1909	41	83%	53	85	71%	0	0
BELLARY	2724	122	1104	50	80%	53	85	63%	0	0
BIDAR	1660	101	597	36	76%	53	85	67%	0	0
BIJAPUR	2289	115	578	29	67%	53	85	64%	0	0
CHAMARAJANAGAR	1482	140	577	54	75%	55	85	85%	0	0
CHIKKABALLAPUR	1595	128	665	53	82%	53	85	56%	0	0
CHIKMAGALUR	1103	88	422	34	83%	53	85	67%	0	0
CHITRADURGA	2382	143	1065	64	82%	65	85	72%	0	0
DAKSHINA KANNADA	2012	96	829	40	80%	53	85	54%	0	0
DAVANAGERE	2245	114	873	44	77%	53	85	55%	0	0
DHARWAD	1803	102	690	39	81%	53	85	61%	0	0
GADAG	1045	98	510	48	82%	53	85	62%	0	0
GULBARGA	3822	111	1314	38	68%	53	85	49%	0	0
HASSAN	1856	98	792	42	82%	53	85	70%	0	0
HAVERI	1549	98	648	41	82%	53	85	68%	0	0
KODAGU (Hilly Dist.)	400	67	191	32	83%	53	85	85%	0	0
KOLAR	1513	99	665	44	80%	53	85	77%	0	0
KOPPAL	1725	131	859	65	85%	66	90	78%	0	0
MANDYA	2152	111	949	49	82%	53	85	73%	0	0

MYSORE	3968	137	1487	51	78%	53	85	74%	0	0
RAICHUR	2809	155	1197	66	81%	67	85	79%	0	0
RAMANAGARA	1300	112	534	46	66%	53	85	62%	0	0
SHIMOGA	1915	106	799	44	81%	53	85	62%	0	0
TUMKUR	3155	111	1369	48	78%	53	85	76%	0	0
UDUPI	1080	88	464	38	82%	53	85	89%	0	0
UTTARA KANNADA	1325	89	458	31	80%	53	85	51%	0	0
<b>TOTAL</b>	<b>66710</b>	<b>115</b>	<b>25995</b>	<b>45</b>	<b>78%</b>	<b>53</b>	<b>85</b>	<b>67%</b>	<b>0</b>	<b>0</b>

\* Patients put on treatment under DOTS regimens only are to be included.

Section B – List Priority areas at the State level for achieving the objectives planned:

S.No.	Priority areas	Activity planned under each priority area	
1	Increasing the Case detection rate at poorly performing Districts	a	Training of all MOs and paramedical staff Filling of vacant posts
		b	Review of poor performing TUs and DMCs and following the action taken after review
		c	frequent supervision of quality of microscopic examination at DMCs
		d	Reduce Initial defaults by tracking all the sputum positive patients
		e	Increased ACSM activities to create awareness among public
2	Increasing the Success rate and bringing down the Defaulter & Death rate.	a	Intensified supervision and monitoring at district and state level
		b	Regular programme review at all levels and Institution-wise analysis and action
		c	Sputum collection & transport from centres in remote & difficult areas
		d	Strengthen the DOT centers

		e	Strengthening the involvement of PPs and NGOs
		f	Intensified case holding and timely retrieval of defaulters.
3	Active Implementation of Intensified TB HIV package and collaborative activities	a	Regular supervision of ICTCs and DMCs in developing Co-ordination
		b	Tracking and prioritization of Co infected patients in CPT provision and ART provision.
		c	Strengthen the ICF at high HIV settings
		d	Regular review of cross referral activities at ART center.
		e	Involvement of NGOs Involved in targeted intervention programme in Implementation of Intensified TB HIV package
4	Feed Back Activities  Provision of regular feedback from state to District and Dist to Sub District.	a	Conducting regular inter district meetings wherever necessary and taking feed backs and action.
		b	Conducting interstate meeting atleast once in quarter.
		c	Regular monthly meeting at worker level and MO level and prioritizing review of RNTCP.
5	Increase the involvement of all specialties in the Medical College in implementing	a	Conducting regular core committee meeting every quarter.

	RNTCP.	b	Joint supervision to medical colleges by STO and STF.
		c	Regular sensitization programme and conducting CMEs in medical colleges.
6	Strengthening the Involvement of NGOs, PPs & Other sectors in RNTCP.	a	Supporting the NGOs PP activities through involving in various schemes in all districts.
		b	Sensitizing the NGOs PPs regularly and strengthen participation of IMA at state and district level
		c	Providing all the facilities in time to strengthen the activities.
7	Prioritizing IEC Activities	a	Efforts to be taken to use all media/communication network in implementing awareness on RNTCP.
		b	Innovative Efforts in developing IEC material by taking feedback from NGO/Private Organisation.
		c	Timely providing printing IEC materials from state to districts
		d	Strengthen the public involvements through conducting meetings and exhibitions.
8	Establishment of IRL and implementation of DOTS Plus Activity.	a	Completion of Civil works of IRL and making it functioned by June –July 2010.

*Priority Districts for Supervision and Monitoring by State during the next year*

<i>S No</i>	<i>District</i>	<i>Reason for inclusion in priority list</i>
1	<b>Bijapur</b>	<b><i>Poor performance in suspects examinations, annualised NSP detection, sputum conversion rate and cure rate. High in death rate, High % of TB HIV Co- infection.</i></b>
2	<b>Gulbarga</b>	<b><i>Poor performance in suspects examinations, annualised NSP detection, sputum conversion rate and cure rate. High in initial defaulter rate</i></b>
3	<b>Bagalkot</b>	<b><i>Poor performance in annualised NSP detection, sputum conversion rate and cure rate. High in death rate High % of TB HIV Co- infection.</i></b>
4	<b>Ramanagar</b>	<b><i>Poor performance in annualised NSP detection, sputum conversion rate and cure rate. High in death rate&amp; defaulter rate.</i></b>
5	<b>Bidar</b>	<b><i>Poor performance in suspects examinations, annualised NSP detection, sputum conversion rate.</i></b>
6	<b>Bruhath Bangalore Mahanagara Palike</b>	<b><i>Poor performance in annualised NSP detection, sputum conversion rate and cure rate. High in initial defaulter rate</i></b>
7	<b>Davanagere</b>	<b><i>Poor performance in annualised NSP detection, cure rate</i></b>

		<i>and High in initial defaulter rate.</i>
8	<b>Bellary</b>	<i>Poor performance in NSP detection, cure rate &amp; high incidence of initial defaulter rate.</i>
9	<b>Belgaum</b>	<i>Low case detection rate, high incidence of initial defaulter rate.</i>

*Section C – Consolidated Plan for Performance and Expenditure under each head, including estimates submitted by all districts, and the requirements at the State Level*

**1. Civil Works**

Activity	No. required as per the norms in the state	No. already upgraded/ present in the state	No. planned to be upgraded during next financial year	Pl provide justification if an increase is planned in excess of norms (use separate sheet if required)	Estimated Expenditure on the activity	Quarter in which the planned activity expected to be completed
	(a)	(b)	(c)	(d)	(e)	(f)
<b>STDC/ IRL</b>	1	1	0		50000	3 <sup>rd</sup> quarter 2010
<b>SDS</b>	1	1	0		200000	NA
<b>DOTS Plus Site</b>	<b>1</b>	<b>0</b>	<b>1</b>	**	800000	<b>3<sup>rd</sup> quarter 2010</b>
<b>DTCs</b>	31	30	1	#	475000	<b>2<sup>nd</sup> Quarter 2010</b>
<b>TUs</b>	125	125	1	*	156800	<b>2<sup>nd</sup> -3<sup>rd</sup> Quarter 2010</b>
<b>DMCs</b>	644	644	0		618200	NA
<b>TOTAL</b>					<b>2300000.00</b>	

\*New DMC at Bellary District Siriguppa Thaluk, # New DTC to newly formed Yadgiri District, \*\* New building construction for DOTs Plus Site.

## 2. Laboratory Materials

Activity	Amount permissible as per the norms in the state	Amount actually spent in the last 4 quarters	Procurement planned during the current financial year (Rs.)	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ Remarks for (d)
	(a)	(b)	(c)	(d)	(e)
<b>Purchase of Lab Materials by Districts</b>	8791950	7790034	4700000	8791950	Prices of the Lab Consumables have increased compared to previous year's and requirement is also increased.
<b>Lab materials for EQA activity at STDC (eg. Lab consumables for trainings, preparation of Panel slides etc)</b>	879195	40266	300000	808050	Procurement of Lab Consumables for IRL will be initiated and completed after establishment and functioning of IRL.
<b>Lab materials &amp; consumables for Culture/DST activity at IRL and other Accredited Culture &amp; DST labs in Govt. sector including Medical Colleges</b>	0	0	0	0	
			<b>TOTAL</b>	<b>9600000.00</b>	

### **3. Honorarium**

Activity	Amount permissible as per the norms in the state	Amount actually spent in the last 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ Remarks for (d)
	(a)	(b)	(c)	(d)	(e)
Honorarium for DOT providers (both tribal and non tribal districts)	1641000	1255500	4457000	<b>2500000.00</b>	Outstanding payment of Honorarium is Rs.5325000.00 which is due from 2007-08 due to insufficient funds. <b>Additional required funds to clear outstanding.</b>
Honorarium for DOT providers of Cat IV patients					

	No. presently involved in RNTCP	Additional enrolment proposed for the next fin. year
Community volunteers in all the districts*	23632	

\* These community volunteers are other than salaried employees of Central/State government and are involved in provision of DOT e.g. Anganwadi workers, trained dais, village health guides, ASHA, other volunteers, etc.

## Annual Action Plan Format Advocacy, Communication and Social Mobilization (ACSM) for RNTCP

- 1) Information on previous year's Annual Action Plan
  - a) Budget proposed in last Annual Action Plan: 5987800
  - b) Amount released by the state: 3000000
  - c) Amount Spent by the district- 1314450
- 2) Permissible budget as per norm : 6343750
- 3) Budget for next financial year for the district as per action plan detailed below:- **3000000**

Program Challenges to be tackled by ACSM during the Year 20010-11	WHY  ACSM Objective	For WHOM  Target Audience	WHAT		When				By WHOM	Monitoring and Evaluation		Budget
			ACSM Activities	Media/	Q1	Q2	Q3	Q4		Outputs;	Outcomes:	
Based on existing TB indicators and analysis of communication challenges  (Maximum Challenges ) 3	Desired behavior or action (make SMART: specific, measurable, achievable, realistic & time bound objectives)		Activities	Material Required					Key implementer and RNTCP officer responsible for supervision	Evidence that the activities have been done	Evidence that it has been effective	Total expenditure for the activity during the financial year
<b>Challenge 1.</b>	Improve case detection	PRI Members	Sensitization	DVD CD LCD Printing/ Flip books	Q1				STO/ DTO/ IEC officer	MPW Modules	Yes good result	26400
Advocacy	Effective communication	Awareness general public	SHG	DVD CD LCD Printing/ Flip books		Q2			STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	13200
Activities	Defaulter retrieval	Awareness general public	Beady Workers	DVD CD LCD Printing/ Flip books			Q3		SOT/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	13200

	Awareness to put	City Corporation Worker	Awareness general public	DVD CD LCD Printing/ Flip books				Q4	STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	13200
Communication	Use DOTs Stop TB	Paper advertising (State Level ) One time	Awareness general Public	Print Media				Q4	STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	99000
Activities	One to one interacting	Awareness general Public	Press meet (Conference)	Print Electronic Media			Q3		STO/ DTO/ IEC officer	TB Message	Yes good result	33000
	Reach the Goal	Awareness general Public	Radio Ads & Cable TV ads	Electronic Media		Q2			STO/ DTO/ IEC officer	Cure & Success Rate	Yes good result	132000
	Free Treatment	Awareness general Public	Kannada Major TV Channel Ads	Electronic Media	Q1				STO/ DTO/ IEC officer	DVD/ CD Documentary	Yes good result	115800
	Free diagnosis	Awareness general Public	Panel discussion on TB (TV Channel)	Electronic Media			Q3		STO/ DTO/ IEC officer	DVD/ CD Documentary	Yes good result	66000
Social Mobilization	Training to SHG/others	Awareness general Public	DOT Directory	Print Media					STO/ DTO/ IEC officer	Question and Answer	Yes good result	66000
Activities	Improve case detectetion	HEW Workers/ others		Print Media					STO/ DTO/ IEC officer	Worker information	Yes good result	79200
	Effective communication	General Public awareness	Street play by folk artists wall writing in busy public places. Posters display in Govt. Officer	Folk Artist					STO/ DTO/ IEC officer	Theme of RETCH	Yes good result	132000
	Defaulter retrieval	Patients and General Public		Print Media					STO/ DTO/ IEC officer	Writing the message	Yes good result	66000
<b>Challenge 2</b>	Awareness to public	Patients and General Public	City Auto Driver & Association	Print Media					STO/ DTO/ IEC officer	Poster	Yes good result	13200
Advocacy	Use DOTs Stop TB	Awareness to General Public	Plastic Factory Workers	Hand bills / flip books/ DVD/ CD, LCD	Q1				STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	19800
Activities	One to one interacting	Awareness to General Public	KSRTC Drivers	Hand bills / flip books/ DVD/ CD, LCD		Q2			STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	13200

	Reach the Goal	Awareness to General Public	Mini Auto workers	Hand bills / flip books/ DVD/ CD, LCD				Q3	STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	13200
Communication	Free Treatment	Awareness to General Public	Street Play selected area blare	Hand bills / flip books/ DVD/ CD, LCD				Q4	STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	19800
Activities	Free diagnosis	Awareness to General Public	Radio pannel discussion	Hand bills/Information / Team work				Q4	STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	66000
	Training to SHG/others	Awareness to General Public	TV scrolling on TB	Electronic Media				Q3	STO/ DTO/ IEC officer	Use folk artist	Yes good result	66000
	Improve case detectetion	Awareness to General Public	New Concept Documentary on TB	Electronic Media					STO/ DTO/ IEC officer	TB Experts (Doctors)	Yes good result	132000
	Effective communication	Awareness to General Public	Private radio channel sponsored Prig	Electronic Media				Q2	STO/ DTO/ IEC officer	Send Message	Yes good result	66000
Social Mobilization	Defaulter retrieval	Awareness to General Public	TB messages Tim plates	Electronic Media	Q1				STO/ DTO/ IEC officer	Video message	Yes good result	66000
Activities	Awareness to public	General Public awareness	Posters Hand bills travel calendars	Print Media					STO/ DTO/ IEC officer	Panel discussion	Yes good result	66000
	Use DOTs Stop TB	General Public awareness	Sun boards for public institution	Print Media					STO/ DTO/ IEC officer	Printed metal sheets	Yes good result	66000
<b>Challenge 3</b>	One to one interaction	PPM/PHI/ others	DOT for PPM on TB for Bangalore Doc	Print Media					STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	66000
Advocacy	Reach the Goal	Sensitization	School Maser/ Head Master	DVD CD LCD Printing/ Flip books	Q1				STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	13200
Activities	Free Treatment	Awareness to General Public	Mahila manual	DVD CD LCD Printing/ Flip books				Q2	STO/ DTO/ IEC officer	DVD/CD/ LCD flip book	Yes good result	13200

	Free diagnosis	Awareness to General Public	Garment factory workers	DVD CD LCD Printing/ Flip books			Q3		STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	13200
	Training SHG/others to	Awareness to General Public	Slum dwellers	DVD CD LCD Printing/ Flip books			Q4		STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	13200
Communication	Use DOTs Stop TB	Awareness to General Public	Preparation TB Spots	DVD CD LCD Printing/ Flip books		Q2			STO/ DTO/ IEC officer	TV spots	Yes good result	13200
Activities	One to one interaction	General Public	Preparation of Radio Jingles	Electronic Media	Q1				STO/ DTO/ IEC officer	TB message sticker	Yes good result	132000
	Reach the Goal	Awareness to General Public	SMS to General Public	Electronic Media		Q2			STO/ DTO/ IEC officer	TB messages	Yes good result	66000
	Free Treatment	Awareness to General Public	IEC mobile van stickening	Information selected Network			Q3		STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	132000
Social Mobilization	Free diagnosis	Awareness to General Public	Flex charts for PHC, DMC, PHI	Information / TB Logo / treatment			Q4		STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	33000
Activities	Training SHG/others to	Awareness to General Public	Flex Hording some selected places	Print Media					STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	52800
	Use DOTs Stop TB	Awareness to General Public	Repaintings of Big Hoardings- 12 places	Print Media					STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	132000
C Facilitation Salary	ACSM Activities by CF	Awareness to General Public	ACSM activities in difference places	Print Media					STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	66000
		Awareness to General Public		Electronic Media / Print Media	Q1	Q2	Q3	Q4	STO/ DTO/ IEC officer	Hand Bills/ Flex Chart	Yes good result	792000
										<b>Grand Total</b>	<b>3000000</b>	

**5. Equipment Maintenance:**

Item	No. actually present in the state	Amount actually spent in the last 4 quarters	Amount Proposed for Maintenance during current financial yr.	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ Remarks for (d)
	(a)	(b)	(c)	(d)	(e)
<b>Computer</b> (Maintenance includes AMC, software and hardware upgrades, Printer Cartridges and Internet expenses)	32	1063927	600000	960000	Estimation made as per the Financial Norms.
<b>Binocular Microscopes (RNTCP)</b>	660	16966	990000	940000	AMC for 660 Microscopes is already made at the rate of 1500/ Microscope. The firm has not provided the details of Service provided and not claimed the bill. However this year the budget will be utilised after payment .
<b>STDC/ IRL Equipment</b>					
<b>Any Other (pl. specify)</b>					
<b>TOTAL</b>				1900000.00	

Training:									
Activity	No. in the state	No. already trained in RNTCP	No. planned to be trained in RNTCP during each quarter of next FY (c)				Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year (Rs.)	Justification/ remarks
			Q1 Q4	Q2	Q3				
	(a)	(b)					(d)	(e)	(f)
Training of DTOs (at National level)									Training to Para Medical Staff could not be carried out due to insufficient funds during the last year.  The cost of Training is increased as per the Revised NRHM norms considerably compared to RNTCP norms, in respect of DA, Honorarium and Food Expenses.  Further the policy of RNTCP and the modules have been revised and therefore all cadre of staff need reorientation training.
Training of MO-TCs				10	20	10		466000	
Training of MOs (Govt + Non-Govt)	4895	4331	70	74	75	48	1200125	864883	
Training of LTs of DMCs- Govt + Non Govt	604	470	86	37	37	16	188200	284850	
Training of MPWs	13290	10194	300	253	272	223	804602	1195153	
Training of MPHS, pharmacists, nursing staff, BEO etc	6152	4930	115	205	143	103	1058976	872296	
Training of Comm Volunteers	11500	2203733	256	296	296	301	304148	573924	
Training of Pvt Practitioners	5865	1452	133	152	131	176	1155260	793179	
Other trainings # Re- training of MOs	3690	754	127	127	166	130	1010228	761780	
ASHA Workers	787	42	0	0	0	0	0	0	
TB/HVs	50	48	0	0	0	0	0	0	
Re- Training of LTs of DMCs	414	128	25	27	19	29	795680	223900	
Re- Training of MPWs	8118	1083	0	0	0	0	0	0	
Re- Training of MPHS, pharmacists, nursing staff, BEO	4505	1311	0	0	0	0	0	0	
Re- Training of CVs	2919	132	100	115	100	138	10000	64000	
Re-training of Pvt Practitioners	3079	176	126	196	140	153	118150	299650	
TB/HIV Training of MO-TCs and MOs	3333	1844	59	67	49	48	233780	185131	

<b>TB/HIV Training of STLS,LTs,MPWs, MPHS, Nursing Staff, Community Volunteers etc</b>	13106	2112	162	165	137	158	565965	217716
<b>TB/HIV Training of STS</b>	62	40	15	1	13	3	187800	206750
<b>Training of MOs and Para medicals in DOTS Plus for management of MDR TB</b>	3248		157	138	156	138	430540	574194
<b>Provision for Update Training at Various Levels #</b>	750	17	110	110	112	120	210180	255500
<b>Review Meetings at State Level</b>			1	1	1	1	200000	106294
<b>Any Other Training Activity</b> Asha Workers ,DOTS provider training	310	100						
<b>Accountants Training</b>	30	30		10	10	10	54800	54800

# Please specify

**TOTAL 8000000.00**

**7. Vehicle Maintenance:**

Type of Vehicle	Number permissible as per the norms in the state	Number actually present	Amount spent on POL and Maintenance in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)	(f)
<b>Four Wheelers</b>	32	19	1567649	1540482	2760000	<b>Estimation has been made as per the Financial Norms</b>
<b>Two Wheelers</b>	125	125	2397698	1687500	3140000	
<b>TOTAL</b>					<b>5900000.00</b>	

**8. Vehicle Hiring\*:**

Hiring of Four Wheeler	Number permissible as per the norms in the state	Number actually requiring hired vehicles	Amount spent in the prev. 4 qtrs	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)	(f)
For STC/ STDC	1	1	6525	50000		Funds are needed for Vehicle Hiring for STDC Director and for IRL Inspection.
For DTO	13	13	1940151	2252000	3000000	<p>Estimation for DTOs Vehicle Hiring has been made as per the Financial Norms For 13 DTOs the hiring charges for vehicle will be</p> <p><b>Rs=750*25*12*13=2925000</b></p>
For MO-TC	125	125				
						<p>Vehicle hiring charges for MO-TCs for supervisory visits</p> <p><b>=125*750*7*12=7875000</b></p> <p>Due to insufficient funds the Vehicle hiring charges to MOTCs is outstanding at many Districts in the previous years is added to the present requirement.</p>
TOTAL					<b>3000000.00</b>	

\* Vehicle Hiring permissible only where RNTCP vehicles have not been provided

**9. NGO/ PP Support:**

Activity	No. of currently involved in RNTCP in the state	Additional enrolment planned for this year	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)	(f)
NGOs involvement scheme 1	3	2			70000	
NGOs involvement scheme 2						
NGOs involvement scheme 3						
NGOs involvement scheme 4						
NGOs involvement scheme 5						
NGOs involvement unsigned						
Private practitioners scheme 1						
Private practitioners scheme 2	21	10			25000	
Private practitioners scheme 3A						
Private practitioners scheme 3B						
Prvt Pract. scheme 4A						
Pvt Pract. Scheme 4B						
<b>TOTAL</b>					<b>95000.00</b>	

NGO/ PP Support: (New schemes w.e.f. 01-10-2008)						
Activity	No. of currently involved in RNTCP	Additional enrolment planned for this year	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)	(f)
ACSM Scheme: TB advocacy, communication, and social mobilization	9	22	363288	2572500	1050000	
SC Scheme: Sputum Collection Centre/s	11	26		610000	360000	
Transport Scheme: Sputum Pick-Up and Transport Service	24	12		530000	144000	
DMC Scheme: Designated Microscopy Cum Treatment Centre (A & B)	11	15	351500	2205000	1050000	
LT Scheme: Strengthening RNTCP diagnostic services		1			150000	
Culture and DST Scheme: Providing Quality Assured Culture and Drug Susceptibility Testing Services						
Adherence scheme: Promoting treatment adherence	2	17		640000	1091000	
Slum Scheme: Improving TB control in Urban Slums	12	17		590000	790000	
Tuberculosis Unit Model	1				630000	
TB-HIV Scheme: Delivering TB-HIV interventions to high HIV Risk groups (HRGs)		7		160000	640000	
<b>TOTAL</b>					<b>6000000.00</b>	

**10. Miscellaneous:**

Activity* e.g. TA/DA, Stationary, etc	Amount permissible as per the norms in the state	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year  (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)
Transportation of Drugs					<b>Estimation is being made as per the Financial Norms.</b> The cost of Loading & Unloading of Drugs , transportation of drugs to Districts, Miscellaneous Exp. IRL/DOTS Plus, increase in cost of TA/DA as per NRHM Norms
TA/DA					
Purchase of Stationary					
Office					
Loading & Unloading of Drugs					
Travelling expences of MDR-TB Patients					
Electricity,Telephon e, Fax,Postage etc.	<b>9491950</b>	<b>4875904</b>	<b>4753000</b>	9500000	
<b>TOTAL</b>				9500000.00	

- *Please mention the main activities proposed to be met out through this head*

<b>11. Contractual Services:</b>							
<b>Category of Staff</b>	<b>No. permissible as per the norms in the state</b>	<b>No. actually present in the state</b>	<b>No. planned to be additionally hired during this year</b>	<b>Amount spent in the previous 4 quarters</b>	<b>Expenditure (in Rs) planned for current fin. year</b>	<b>Estimated Expenditure for the next financial year (Rs.)</b>	<b>Justification/remarks</b>
	<b>(a)</b>	<b>(b)</b>	<b>(c)</b>		<b>(d)</b>	<b>(e)</b>	<b>Remuneration to New recruitment of Sr. DOT Plus &amp; TB/HIV Supervisors at District level, DOTs Plus MO, Sta. Asst. (DOTs Plus), Sr.LT (IRL), Pharmacist/Store Asst., Store Asst. SDS, Epidemiologist not included in budget. Due to enhancement of remuneration to contractual staff. Recruitment of DEO and Part time Accountant to New</b>
<b>TB/HIV Coord.</b>							
<b>Urban TB Coord.</b>							
<b>MO-STCS</b>	1	0	1	56903	0	360000	
<b>State Accountant</b>	2	2	0	364500	216000	475200	
<b>State IEC Officer</b>	1	0	1	189750	0	216000	
<b>Pharmacist</b>	1	0	1				
<b>Secretarial Asst</b>	1	1	0	98700	51000	112200	
<b>MO-DTC</b>	7	6	1	1015552	2076200	2822400	
<b>STS</b>	125	122	2	11501217	14301394	18435300	
<b>STLS</b>	125	123	1	9921360	14291065	18587600	
<b>TBHV</b>	170	156	14	5724336	14231056	17254800	
<b>DEO (including DEO at IRL)</b>	33	31	2	1939579	2393482	3542100	
<b>Accountant – part time</b>	31	30	1	595550	833320	1171800	
<b>Contractual LT</b>	154	152	2	7901147	8942424	16493400	
<b>Driver</b>	1	1		57983	28992	88200	
<b>Asst Programme Officer/Epidemiologist</b>	1	0	1				
<b>DOTS Plus Site Sr. Medical Officer</b>	1	0	1				

<b>DOTS Plus site Statistical Assistant</b>	1	0	1				<b>Yadgiri District.</b>
<b>Sr. DOTS Plus&amp; TB/HIV Supervisor (district level)</b>	31	0	31				
<b>Sr. LT at IRL</b>	1	0	1				
<b>Store Assistant (State Drug Store)</b>	1	0	1				
<b>Any other contractual post approved under RNTCP Microbiologist</b>	1	1	0	212400	210000	441000	
<b>TOTAL</b>						80000000.0 0	

Note:-The Work Sheet for Calculation of Remuneration to Contractual Staff is enclosed as Annexure-A

**12. Printing:**

Activity	Amount permissible as per the norms in the state	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted  (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)
<b>Printing-State level:*</b> 1. Training Module for MO/STS/STLS/MPW 2. TB/HIV Modules 3. RNTCP at Glance 4. Revised Lab Register 5. Revised TB Register 6. Supervisory Register	2930650	210040		2069500	<b>Printing of Modules for Training could not be taken up due to non availability of revised modules. This fund will be utilised during 2010-11 approximate expenditure will be around Rs.4000000.00</b>
<b>Printing- Distt. Level:*</b> 1. TB Patients Card 2. TB ID Card 3. DOT Director 4. IEC Material 5. Lab Form 6. Referral Forms	5861300	1438683	<b>4268000</b>	2930500	

\* Please specify items to be printed in this column

**TOTAL:-5000000.00**

**13. Research and Studies (excluding OR in Medical Colleges):**

Any Operational Research projects planned (Yes/No) YES

Estimated Total Budget :- **1400000.00**

#### 14. Medical Colleges

Activity	Amount permissible as per norms	Estimated Expenditure for the next financial year(Rs.)	Justification/ remarks
	(a)	(b)	(c)
<b>Contractual Staff:</b> <ul style="list-style-type: none"> <li>▪ MO-Medical College (Total approved in state 18 )</li> <li>▪ STLS in Medical Colleges (Total no in state ___ )</li> <li>▪ LT for Medical College (Total no in state 39 )</li> <li>▪ TBHV for Medical College (Total no in state 39 )</li> </ul>	<p>6350400</p> <p>4176900</p> <p>3931200</p>	<p>3120000</p> <p>3510000</p> <p>3276000</p>	<p>Estimation is being made as per the Financial Norms</p> <p>MO</p> <p>=18*28000*12*1.05=6350400</p> <p>LT</p> <p>=</p> <p>39*8500*12*1.05=4176900</p> <p>TBHV=</p> <p>39*8000*12*1.05+750*12*39</p> <p>=4282200</p>
<b>Research and Studies:</b> <ul style="list-style-type: none"> <li>▪ Thesis of PG Students</li> <li>▪ Operations Research</li> </ul>	500000		<p>Thesis of PG Students</p> <p>=39*20000=780000</p>
<b>Travel Expenses for attending STF meetings</b>	300000	94000	
<b>IEC: Meetings and CME planned</b>	175000		<p>Meeting Expenses at Rs.5000 per Medical College</p> <p>=39*5000=195000</p>
<b>Equipment Maintenance at Nodal Centres</b>			

**TOTAL:- 1000000.00**

**15. Procurement of Vehicles:**

Equipment	No. actually present in the state	No. planned for procurement this year (only if permissible as per norms)	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)
4-wheeler **	21	0	0	
2-wheeler	125	42	0	Out of the 126 Two Wheelers 42 Nos of Two Wheelers have run more than 1Lakh KMs of has been purchased more than 6years ago and therefore need to be replaced as per the norms and a budget of Rs.21Lakhs is required.

\*\* Only if authorized in writing by the Central TB Division

**16. Procurement of Equipment:**

Equipment	No. actually present in the state	No. planned for this year (only as per norms)	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)
Office Equipment (Computer, modem, scanner, printer, UPS etc.)	32	20	1000000	1 Computer each to New Yadgiri District, IRL, STDC, and SDS.Replacement of old Computers which have completed 8years at 16 districts.
Any Other:-				

TOTAL :- **1000000.00**

Section D: Summary of proposed budget for the state –

(Rs. In Lakhs)

<b>Category of Expenditure</b>	<b>Budget estimate for the coming FY 2010 - 2011</b> <i>(Based on the planned activities and expenditure in Section C)</i>
1. Civil works	23.00
2. Laboratory materials	96.00
3. Honorarium	25.00
4. IEC/ Publicity	30.00
5. Equipment maintenance	19.00
6. Training	80.00
7. Vehicle maintenance	59.00
8. Vehicle hiring	30.00
9. NGO/PP support	60.00
10. Miscellaneous	95.00
11. Contractual services	800.00
12. Printing	50.00
13. Research and studies	14.00
14. Medical Colleges	100.00
15. Procurement –vehicles	0.00
16. Procurement – equipment	10.00
17.Total	<b>1491.00</b>

### **17. Additionality Funds from NRHM-**

Additional Funds under NRHM for RNTCP activities (Programme Implementation Plan for 2010-11)

The details of Additional Funds required for the activities for strengthening RNTCP Services, budgeted under the “Additionality”

head of NRHM PIP for the period 2010-11.

- (1) Rs. 36 Lakhs for STDC(IRL) Civil Works, Electric Back up generator, Fabrication for walk in cold room and walk in incubator rooms.
- (2) Rs.10.40 Lakhs to bear Travelling expences of DOTs Plus Patients and investigations in DOTs Plus Patients
- (3) Rs.3.60 Lakhs for Man Power i.e. 5 Lab attendents at IRL

**Total from NRHM Additionalities Rs.50 lakhs/-**

## CHAPTER 31

### NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF DEAFNESS

#### Introduction:

**328.** Hearing loss is the most common sensory deficit in humans today. As per WHO estimates in India, there are approximately 63 million people, who are suffering from significant auditory impairment; this places the estimated prevalence at 6.3% in Indian population. As per NSSO survey, currently there are 291 persons per one lakh population who are suffering from severe to profound hearing loss (NSSO, 2001). Of these, a large percentage is children between the ages of 0 to 14 years. With such a large number of hearing impaired young Indians, it amounts to a severe loss of productivity, both physical and economic. An even larger percentage of our population suffers from milder degrees of hearing loss and unilateral (one sided) hearing loss.

#### **329. OBJECTIVES OF THE PROGRAMME**

To **prevent** the avoidable hearing loss on account of disease or injury.

- a) Early identification, diagnosis and treatment of ear problems responsible for hearing loss and deafness.
- b) To **medically rehabilitate** persons of all age groups, suffering with deafness.
- c) To **strengthen the existing inter-sectoral linkages** for continuity of the rehabilitation programme, for persons with deafness.
- d) To **develop institutional capacity** for ear care services by providing **support for equipment and material and training personnel**.

Long term objective: To prevent and control major causes of hearing

impairment and deafness, so as to reduce the total disease burden by 25% of the existing burden by the end of eleventh five year plan.

### **330. STRATEGIES**

- a) To strengthen the service delivery including rehabilitation.
- b) To develop human resource for ear care.
- c) To promote outreach activities and public awareness through appropriate and effective IEC strategies with special emphasis on prevention of deafness.
- d) To develop institutional capacity of the district hospitals, community health centers and primary health centers, selected under the project.

### **EXPECTED BENEFITS OF THE PROGRAMME**

**331.**The programme is expected to generate the following benefits in the short as well as in the long run.

- i. Large scale direct benefit of various services like prevention, early identification, treatment, referral, rehabilitation etc. for hearing impairment and deafness as the primary health center / community health centers / district hospitals largely cater to their need.
- ii. Decrease in the magnitude of hearing impaired persons.
- iii. Decrease in the severity/ extent of ear morbidity or hearing impairment in large number of cases.
- iv. Improved service network for the persons with ear morbidity/hearing impairment in the states and districts covered under the project.
- v. Awareness creation among the health workers/grassroot level workers through the primary health centre medical officers and district officers which will percolate to the lowest level as the lower level health workers function within the community.
- vi. Larger community participation to prevent hearing loss through panchyati raj institutions, mahila mandals, village bodies and also creation of a collective responsibility framework in the broad spectrum of the society.

vii. Leadership building in the primary health centre medical officers to help create better sensitization in the grassroots level which will ultimately ensure better implementation of the programme.

viii. Capacity building at the district hospitals to ensure better care.

ix. State of the art department of ENT at the medical colleges in the state/union territory under the project.

**332.** The NPPCD programme is in various levels of implementation in 12 districts, 3 districts- Mandya, Hassan & Dharwad, pilot phase districts 2006-8 & 3 additional districts –Kolar, Udupi & Gadag in 2008-9 and six new districts – Chitradurga, Chamarajanagar, Bijapur, Tumkur, Chikkamagalur, & Haveri were taken up for expansion of NPPCD for year 2009-10, It is proposed to extend the same to 6 districts- Kodagu, Uttara Kannada, Ramanagara, Chikkaballapur, Bangalore rural and Bagalkot.

- The programme was formally launched by the Hon. Minister & Secretary HFW in Kolar on 13/2/09 and the first batch of 58 hearing aids was distributed to the needy beneficiaries as per the guidelines issued by GOI.
- The capacity building- District hospital & PHC/CHC for the six districts Mandya, Hassan Dharwad, Kolar, Udupi & Gadag are completed and for the new districts approved in 2009-10 are underway.
- Audiological assistants have been appointed in the three districts- Mandya, Hassan Dharwad, and regular screenings are going on.
- The training of Medical and other personnel in cascading fashion has been completed in the three pilot phase districts. and are proposed to be taken up in other districts.
- ENT screening camps have been conducted in all the six districts on 22<sup>nd</sup> of every month at district HQ and 15<sup>th</sup> of every month at Taluk hospitals. More than 1000 hearing aids have been fitted to the beneficiaries.

**333.** A total of 7.6 lakhs school children have been given Health checkup under Suvarna Arogya Chaitanya Program and 25385 children have been identified with otitis media among whom 19810 have been treated & 3664 children had hearing problems out of whom 1888 have been treated.

**Table-66**

<b>Sl. No.</b>	<b>Activities</b>	<b>Allocation for Districts</b>	<b>Approved for 10-11</b>
<b>1</b>	Capacity Building		
	District Hospital	8	76.00
	PHC/CHC	385	38.50
<b>2</b>	Training	12	48.00
<b>3</b>	Screening camps	18	21.60
<b>4</b>	Contractual manpower	18 (12x2x7500x12)	32.40
<b>5</b>	Hearing Aids		
	200/dist/year	12	58.39
<b>7</b>	State cell		4.22
		<b>Total</b>	<b>279.11</b>

## Chapter-32

### NATIONAL MENTAL HEALTH PROGRAMME

#### Introduction:

- 334.** Health includes Mental Health. Mental Health problems are increasing day by day and according to WHO is going to be a major public health problem. 25% of patients attending any OPD in any hospital have mental health problems. Modern and scientific treatment for mental illness is available in big cities and is costly, forcing our community to approach faith healers, temples, etc., leading to morbidity, chronicity, disability and loss of man power.
- 335.** Making treatment availability at Primary Health Centers is the only answer to this problem in developing countries. Karnataka's Bellary District Mental Health Programme (1985-1990) has shown that PHC doctors can identify and treat 80% of mental health problems. Integration of '**Mental Health Care**' into the existing **General Health Care** is the main aim of district mental health programme. This DMHP is nearer to people, cheaper, cost effective and most accepted by community as Mental Hospitals and psychiatrists have **Social Stigma** attached to them. Early identification of mental illnesses and treatment of PHC leads to good cure, decreases disability, stigma and discrimination by society and also the work load on poorly man powered Mental Hospitals.
- 336.** Hence, DMHPs were sanctioned by Government of India, Ministry of Health, during 9<sup>th</sup> and 10<sup>th</sup> Plans. Karnataka also has 4 DMHP sanctioned in 10<sup>th</sup> Plan. The Govt. of Karnataka has proposed to implement DMHP in 10 more districts and extend it to all districts during 11<sup>th</sup> Plan and proposals are submitted to GOI in August 2008, but awaiting 10<sup>th</sup> plan **Evaluation Report** of DMHP, sanction and release of grants is being delayed. Hence it is proposed to start **10 more DMHPs** in Karnataka through NRHM funds.
- 337. The main components of District Mental Health Programme**

- a) **Appointment of Contractual Staff:-** 1 Psychiatrist, 1 Clinical Psychologist, 1 Psychiatric Social Worker, 1 Psy. Nurse, 1 Clerk cum Computer Operator and 1 Group D at Dist. Health Office (DMHP-team)
- b) **Training: - Training** of Medical Officers for 3 days every year at Dist. level, other Para-medical staff for 1 day at Taluk place and AWW/ASHA/VHSC members for ½ day at PHC level.
- c) **Supply of Drugs: -** Common Psy. Drugs are to be supplied to all Primary Health facilities is an important part of DMHP.
- d) **Records and Reporting:-** Each patient treated is recorded in a separate case sheet and the progress reported monthly to the district and to the state.
- e) **IEC activities:-** Most essential in DMHP for the community acceptance, participation and removal of stigma.

Each DMHP needs Rs.26.20 lakhs per district funds for 1 year.

1. Staff Salary	Rs. 8.70 lakhs
2. Training	Rs. 6.00 lakhs
3. Drug Supply	Rs. 4.00 lakhs
4. Records/Reporting and POL to transport	Rs. 3.00 lakhs
5. IEC Activity	Rs. 2.00 lakhs
<u>6. Office maintenance &amp; Misc.</u>	<u>Rs. 2.50 lakhs</u>

**338. Proposals for grant of II year fund for Dist Mental Health Programme (DMHP) for 2010-11**

- Karnataka State has already 4 DMHPs sanctioned in 2003-04 by GOI (10<sup>th</sup> Five Year Plan) vide No: V-15011/6/2003-PH(Pt) dated Jan 2004, and I year grant of Rs.26.20 lakhs was released to these Dists.
- The DMHP is implemented in the Dists of Gulbarga, Chamrajanagar, Shimoga and Karwar. Appointment of contractual staff (except Psychiatrist), purchase of drugs,

training of MOs and Para-Med. Staff, IEC activities are undertaken in these dists. for the last 4 years.

- The expenditure statement and utilization certificates are sent to GOI every year, the latest being addressed to Sri. Padmanabha, the Under Secretary to GOI, MOH, New Delhi (No: HET/MH/14/09-10 dt :24-6-09)
- The financial progress of DMHP up to end of October (Rs In Lakhs)

**Table-67**

Districts	Grants Received	Expenditure up to Oct-09	Balance
Gulbarga	26.20	22.92	3.28
Chamarajnagar	26.20	19.33	6.87
Karwar	26.20	20.10	6.10
Shimoga	26.20	22.28	3.92

- Progress under training of Doctors and Para medical staff

**Table-68**

Districts	Doctors Trained Once	Doctors Trained Twice	Paramedical Trained Once	Para Medical Trained Twice
Gulbarga	230	171	732+844	Aww-Trg
Chamarajnagar	149	81	553	224-June-329-Aug
Karwar	78	98	435	560- June-08
Shimoga	147	108	605	547-may-08

- Patients identified and treated upto end of Oct, 09

**Table-69**

Dist.	New cases detected during the month					Total cases treated				
	EPI	PSY	NEU	MR	Total	EPI	PSY	NEU	MR	Total
C-nagar	13	14	4	0	31	4157	1565	1774	967	8463
Shimoga	14	4	36	0	54	1362	457	1025	329	3173

Karwar	30	54	29	9	122		1911	1521	1574	1540	6546
Gulbarga	44	21	72	11	148		2307	832	1486	779	5404
<b>Total</b>	<b>101</b>	<b>93</b>	<b>141</b>	<b>20</b>	<b>355</b>		<b>9737</b>	<b>4375</b>	<b>5859</b>	<b>3615</b>	<b>23586</b>

430. II Year grants of Rs. 21.80 lakhs for each of the 4 Dists are requested for 2010-11 through NRHM. This amount according to GOI guidelines is for the following components.

1. Staff = Rs.9.30 lakhs
2. Medicine/Stationery/Contingency = Rs.5.50 lakhs
3. Training = Rs.5.00 lakhs
4. IEC = Rs.2.00 lakhs

**Total = 21.80 lakhs x 4 Districts = Rs. 87.20 Lakhs**

**Table-70**

**BUDGET FOR MENTAL HEALTH PROGRAMME**

B)	Continuation 4DMHPs.....	of	Rs.21.80 x 4 =Rs. 87.20
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## CHAPTER-33

### Programme Management

#### **Introduction;**

**339.**Health & Family Welfare Department is implementing various Health service activities under Maternal and Child Health and Disease Control Programmes since the inception of NRHM in the state of Karnataka. In order to improve the performance of various programs under NRHM the services of Deputy Directors, as Programme Officers, Professional Managers and the Consultants have been entrusted to achieve the goals and strengthen the health services in rural and remote areas. The traditional Health Programs along with the NRHM initiatives and innovations in terms of programmatic support, schemes & innovative financing have to be professionally monitored and enforce at all levels to attain tangible results including the attainment of Millennium Development Goals.

#### **Plans objectives and strategies of implementation**

**340.**In order to manage the programmes of NRHM the state has created managerial secretariat system at state, district and taluka levels through the State Programme Management Unit, District Programme Management Unit and The Block Programme Management Unit respectively.

**341.**The State Programme Management Unit (SPMU) being the secretariat at state level for NRHM is having two units namely the Administration and the Finance. The Chief Administrative Officer and the Chief Finance Officer are entrusted to monitor and manage matters pertaining to administration and financial management of SPMU. The Chief Administrative Office is supported by the State Programme Manager and the Administration sections. The State Programme Management Unit conducts regular meetings of the Executive Committee of the State Health Society and the State Mission. The Executive Committee meeting of the Health Society is conducted every month under the chairmanship of the Principal Secretary, Project Director (RCH) is the member secretary of the executive committee of the society. The different components of NRHM are being implemented and reviewed in totality of all stages of planning, programming, process and implementation.

**342.**The Chief Finance Officer is supported by the State Finance Manager, State Accounts Manager and Programme Assistant (Accounts) and the Accounts section. All matters related to administration are being looked after and managed by the **Administrative Unit** and all matters related to finance are administered and managed by the **Finance Unit** of the SPMU.

**343.**The District Programme Management Unit (DPMU) consists of District Programme Manager, District Accounts Manager supported by Data Entry operator and the Programme Assistant from 2008-09 and onwards DPMU is functioning in all the districts. Besides providing secretariat support to District Health Mission and The District Health Society, the District Programme Management Unit is expected to render an effective work of monitoring and management of the NRHM programmes. Therefore during the year 2010-11 it is planned to provide a hired vehicle to each of the district programme managers so that, they could make frequent field visits and watch and report the financial and physical progress of the programme. The DPMU is responsible for conducting regular meetings of district mission and District Health and Family Welfare Society. District Programme Manager would report to the Deputy Commissioner through the District Health Officer as well as to the SPMU at the state level. The DPMU shall ensure the blocks (taluks) to submit monthly / quarterly reports, review, analyze these reports, visits taluks / villages, attending review meetings and recommend corrective measures and action to be initiated. The DPMU responsible to prepare consolidated monthly/ quarterly progress reports highlighting achievements (Physical and financial) following the PIP of the current year, find out reasons for delay/ adverse variance, corrective action to be taken, etc. It is responsible to ensure that agreed corrective action is implemented.

**344.**During the year 2009-10 SPMU has established Block Programme Management Units in every taluk of state. There are 176 taluks and each taluk is having a block programme manager supported by an Accounts assistant and a Data Entry operator. The recruitment process at taluka level has been done by the recruitment committee headed by the Deputy Commissioner of the district. It is planned to have a full fledged periodical reporting system so that the SPMU will have all the first hand information with regard to any administrative lapses in implementation and the utilization of finance.

- 345.** The State Level Consultants recruited under RCH II Programme are assisting the NRHM Programme Division / SPMU very effectively and efficiently. Besides a Nodal Officer to each district have been identified and entrusted the districts from the Health and Family Welfare Services and they shall visit the district every month on definite fixed dates in order to monitor, review and report the progress of the programme. A detailed checklist has been designed covering all items of the programme and the nodal officer shall check each item of the programme with the help of District programme Management Unit and the Block Programme Management Units. The Nodal Officers of the district not only visit the districts on definite in date of month or as often as necessary to the districts and closely monitor the implementation of NRHM activities at different facilities and also interact with the Chief Executive Officer of the Zilla panchayat and the Deputy Commissioner of the district.
- 346.** It is planned to decentralize the planning, programming, implementation, review and evaluation of all the NRHM and other health activities participation of the locally positioned manpower of both government and non governmental agencies at taluka level. The Block Programme Managers are being given training for capacity building so that the programme implementation is fruitful at grassroot level.

**Budget**

<b>A.14.1 Strengthening of State society/ SPMU (Rs. In lakhs)</b>				
<b>Sl.No</b>	<b>Budget Head</b>	<b>Unit cost</b>	<b>No of units</b>	<b>Total Cost</b>
1	Director finance	6	1	6.00
2	State Finance Manager	3.6	1	3.60
3	Tally personnel	3	2	6.00
4	Monitoring team in Handholding Districts	3	4	12.00
5	State Programme Manager	3.00	1	3.00
6	State Accounts Manager	3.00	1	3.00
7	Programme Asst (accounts) Salary	2.40	1	2.40
8	Administrative Assitatan	1.20	3	3.60
9	Accounts Assistant	1.44	3	4.32
10	Statistical Assistant	1.8	5	9.00
11	Computer Assistant	1.20	30	36.00
12	Group D Employees	0.96	12	11.52
13	Payment of Conveyance allowance to consultants and SPM	0.90	8	7.20
14	Vehicle maintainance for SPMU	1.20	3	3.60
15	Contingency expenses for stationary, Post, telephone, TA/DA, meetings, office expense etc.,			73.20

16	Monitoring NRHM Activities by state nodal officers / consultants	0.6	35	21.00
17	Mission meetings, Society meetings/ Governing body meeting expenses etc			17.76
18	Miscellaneous			150.00
<b>TOTAL</b>				<b>373.20</b>
A.14.3	Strengthening of Financial Management systems (tally @ block level + 6 DCPs tally package)	0.135	182	24.57
A.14.4	Other activities (mobility support to district programme managers @ Rs.20,000/-pm and Rs.40,000 to meet monthly meetings, stationary, telephone bills, photo coping etc.at district level)	7.2	30	216.00
<b>TOTAL</b>				<b>240.57</b>
A.14.2	<b>Strengthening of District society/ DPMU (Rs. In lakhs)</b>			
	<b>Budget Head</b>	<b>Unit cost</b>	<b>No of units</b>	<b>Total Cost</b>
1	District Programme Manager Salary	3.00	30	90.00
2	District Accounts Manager Salary	2.40	30	72.00
3	Account Assistant Salary	1.08	30	32.40
4	Dist Data Asst Salary	1.08	30	32.40
	<b>Total</b>			<b>226.80</b>
	<b>Total for Prog.Management</b>			<b>840.57</b>

(Rs. In lakhs)

<b>BPMU</b>				
<b>B28</b>	<b>NRHM Management Costs/ Contingencies</b>			
<b>B28.1</b>	<b>Block Level BPMU</b>			
a	Block programme managers	1.2	176	211.20
b	Block level accounts assistants	0.9	176	158.40
c	Block level data entry operator	0.9	176	158.40
B28.2	Audit Fees			10.00
B28.4	Concurrent Audit system	1.2	30	36.00
<b>B28.8</b>	<b>Other Management Cost</b>			
B28.8.1	Training of District Accounts Managers			5.00
B28.8.2	Management cost	1.8	176	316.80
	<b>Total for programme management</b>			<b>895.80</b>

## **Part – E**

### **CHAPTER-34**

#### **Inter-Sectoral Convergence**

**347.**The inter sectoral convergence efforts in the state of Karnataka focuses on building operational level synergies along with common goals and shared work plans to achieve them; between associated sector departments like Women Development & Child Welfare, Rural Development, Department of Panchayati Raj, AYUSH and Education Department. Budgeted for awareness programmes with interdepartmental officials at district and Taluka level Rs.50 thousand for each district: Rs 15.00 lakhs

#### **Village Health and Water Sanitation Committee**

**348.** The village health and water sanitation committee provides an opportunity for grass root level convergence. The state has already issued notifications for the formation of Village Health and Sanitation Committees at all the villages at the site. These committees are to expected to be fully operationalised in the next few months and will play key role in the decentralized planning process.

#### **Integration of Health department and AYUSH**

**349.**Focused efforts would be made by the state to ensure the integration of the Indian Systems of Medicine to the mainstream health delivery system.

#### **Integration of Health & Rural Development**

**350.**Nutrition along with sanitation is key health determinants in ensuring a healthy population. Also the rural development initiatives compliment the health function through the network of AWWs at the village level. The department of health is in the process of evolving a joint convergence strategy with the rural development department to address the health related issues in a coordinated manner. The following steps are being already considered

- Joint organization of village health days once a month in all villages.
- Sharing of data / joint survey format for household level surveys at all the villages across the state.
- Joint action and work plans at GP and Block level through the decentralized planning exercise.

**Joint strategies with Women and Child Development and Education departments.**

**351.** The following issues will be addressed to evolve a convergence strategy with the woman and child department.

- a) Department should play more pro-active role in women development activities, rather than that on implementing certain activities.
- b) It must coordinate with Health and family welfare department closely
- c) It should impart training in gender and women empowerment among women groups
- d) It should develop IEC material and distribute through its wide network
- e) It should analyse the data of vital events collected by AWWs and disseminate it among local community routinely
- f) It should approve projects for women empowerment
- g) AWWs should motivate the community for 100 % registration of vital events (birth and death) with local registrar within 21 days i.e. Secretary Gram Panchayat

**352.** Education plays a key role in the improvement of overall health of the community. The following issues are expected to be addressed in evolving a convergence strategy among the departments.

- a) Education department should promote positive values amongst children by undertaking various activities
- b) It should willingly accept the responsibility entrusted to it for increasing awareness and behaviour change among students
- c) Girl child must be given its due priority in the schools
- d) There should be no discrimination against girls in the school

e) Due care must be given towards special need of girl students such as toilets in the school

**353.** Already the health and education department has opportunities of cooperation at the implementation of the various school health activities envisaged as a part of the RCH II programme.

### **Structure for Convergence**

**354.**Development of a structure for convergence to address the project implementation goals and objectives and monitoring and review issues in key in ensuring the success of the convergence efforts. The state plans to utilise the opportunity provided by the NRHM suggested structures like the Block Core Groups and District Core Groups for addressing the issue at the district and block level.

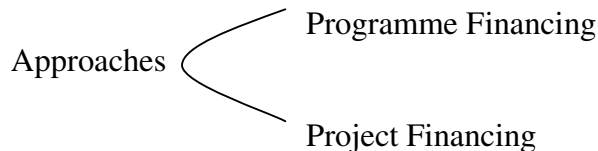
## CHAPTER-35

### Karnataka Health System development and Reforms Project

#### KARNATAKA HEALTH SYSTEM DEVELOPMENT & REFORM PROJECT

**355.** The State of Karnataka has achieved significant progress in important health indicators such as life expectancy, IMR, MMR, Birth and Death rates. But a lot more needs to be done when compared to Kerala and Tamilnadu. There is no doubt that there are systemic weaknesses which obstruct the progress in this vitally important social sector, even though there has been perceptible economic development in the State. The project aims at increasing utilization of quality public and private health services, particularly in underserved areas and amongst vulnerable groups, so as to accelerate achieving of the millennium development goals. The priority health services include promotion of institutional deliveries, immunization, prevention and treatment diarrhea, ARI and other communicable diseases. KHSDRP proposes to strengthen the existing Govt. health programmes for making health services more effective and equitable. The two Development Objectives of KHSDRP are :

1. Increasing utilisation of essential curative and public health services of adequate quality, particularly for the poor and vulnerable.
2. Improving health sector spending, with emphasis on primary and public health.



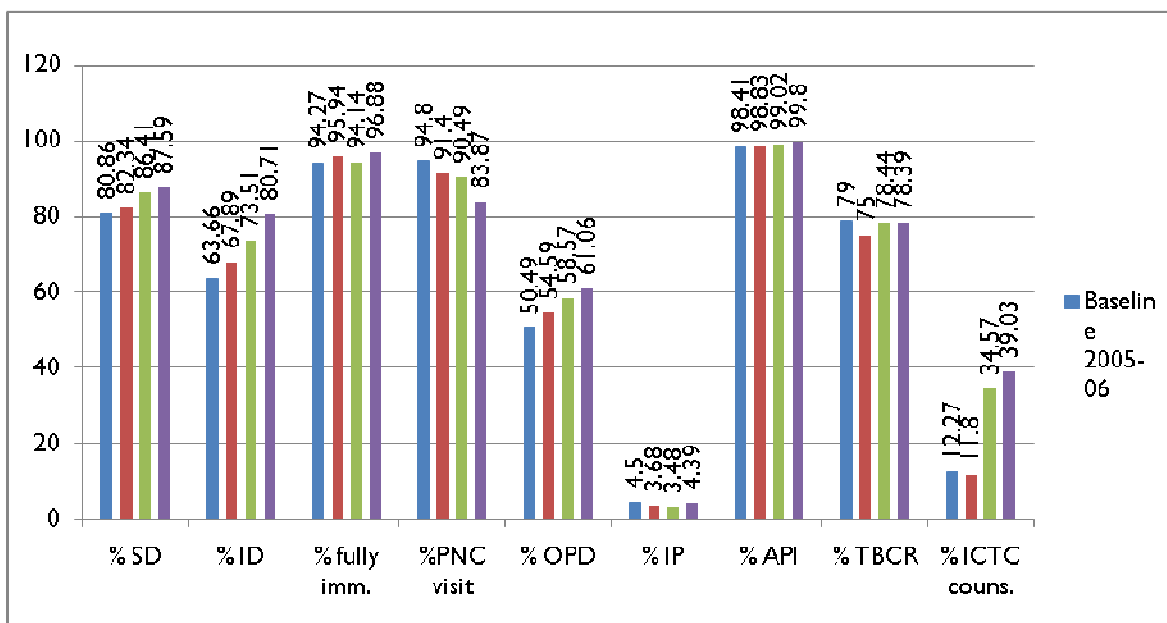
**356.** Programme Financing will provide additional support to existing health care activities of the Department. Project Financing would support innovative activities to improve primary and public health.

**Table-71****KHSDR Project Costs**

<b>Project Component</b>	<b>Cost (INR Million)</b>	<b>Cost (US \$ Million)</b>
<b>A. Strengthening Existing Government Health Programmes.</b>		
1. Organisational Development	220.46	5.07
2. Improving Primary and Secondary Care Services (Programme Financing)	4782.80	110.00
<b>Sub-total</b>	<b>5003.26</b>	<b>115.07</b>
<b>B. Innovations</b>		
1. Service Improvement Challenge Fund	1269.70	29.20
2. Public Health Competitive Fund	400.00	9.20
3. Public Private Partnership	474.90	10.92
4. Special schemes for vulnerable communities and innovative approaches	345.71	7.95
5. Health Financing	445.76	10.25
<b>Sub-total</b>	<b>2936.07</b>	<b>67.52</b>
<b>C. Programme Management</b>		
1. Project Management	370.94	8.53
2. Evaluation	57.67	1.33
3. Monitoring & Information System	230.38	5.30
<b>Sub-total</b>	<b>658.99</b>	<b>15.16</b>
<b>D. Total Baseline Costs</b>	<b>8598.33</b>	<b>197.75</b>
1. Physical Contingencies	171.75	3.95
2. Price Contingencies	207.87	4.78
<b>TOTAL PROJECT COST</b>	<b>8977.95</b>	<b>206.48</b>

Diagram-13

**PROJECT DEVELOPMENT OBJECTIVES - 9 KEY INDICATORS**



There is a significant progress in the 9 PDO indicators.

**Project Components:**

**357. In order to strengthen and reform these key aspects, the project will support the following action-plan**

- **Organisation Development (Capacity building)**
- **Service Improvement Challenge Fund (Infrastructure)**
- **Special schemes for vulnerable communities and innovative approaches (Public Private Partnership, Mobile Health clinics, contracting out PHCs, Contracting in Specialist services, Outsourcing of Regional Diagnostic Labs)**
- **Public Health Competitive Fund**
- **Health Financing (Insurance)**

### **Organisation Development:-**

**358.** The following activities are planned for the department under Organisation Development.

- HRD Programme for Capacity Building
- Development of Model Public Health Act for the Department
- Preparation of Medical Manual
- Capacity building for Group B, C and D
- Study tours
- Creation of various cells for the Department like PPP Cell, Health Finance Cell, Health Care Waste Management Cell, Blood Bank Cell, IEC Cell and Quality Assurance Cell under progress
- Strengthening of SIHFW by providing infrastructure and man power
- OD Consultancy – Embedding leadership excellence among doctors and fostering knowledge for health

### **Service Improvement Challenge Fund (Infrastructure):**

**359.** Under Service Improvement Challenge Fund (Infrastructure), new construction of PHCs and Sub-centres, addition, alteration and renovation of PHCs/CHCs/Sub-centres, construction of State Health Informatics Centre, construction of 9 ANMTCs, construction of 13 drug warehouses, addition, alteration for 19 DTCs and 4 Regional Training centres are taken up. In the first phase of the project, 35 PHCs and 152 Sub-centres are taken up for construction work and all the works are nearing completion. The equipment / furniture will be supplied for all these newly constructed PHCs/Sub-centres. The selection for infrastructure was done by giving more priority to backward taluks as per Nanjundappa Committee's report.

### **Service Improvement Challenge Fund (innovative Schemes):**

**360.** Special schemes for vulnerable communities and innovative approaches

- Public Private Partnership – 20 PHCs are proposed for contracting out (Arogya Bandhu Scheme)
- Mobile Health clinics – It is proposed to start 69 Mobile Health Clinics for the underserved and unreached areas. **Phase I** – 5 Mobile Health Clinics were made operationalised at 5 taluks – Sagar, Tarikere, Chamarajanagar, Kollegal and Kumta from June 2008. **(2154 camps conducted and 73,869 beneficiaries treated).** **Phase II** – 14 Mobile Health Clinics were made operationalised from March 2009 in 9 districts – Bangalore (U)-1, Chikkaballapur-1, Shimoga-1, Tumkur-1, Mysore-

1, Belgaum-3, Bagalkote-1, U.K.-4, Bidar-1. **(2148 camps conducted and 92439 beneficiaries treated).**

- Contracting in Specialist services – Under KHSDRP, it is proposed to contract-in specialist services for District Hospitals, Taluk Hospitals and CHCs for all the specialities case to case basis and OPD basis.
- Outsourcing of Regional Diagnostic Labs - 3 RDL are taken up for outsourcing under KHSDRP.

### **Public Health Competitive Fund:**

**361.** Public Health Competitive Fund will support any activity other than clinical and curative services, which can improve the health status of the community particularly if the community is poor and disadvantageous. These activities will be included non-clinical activities for immunization, vector control, IEC for behavioural change, sanitation and hygiene, etc. The proposals under PHCF will be assessed on the following aspects – appropriateness, technical content, implementation potential, control systems and measurable results. The following activities are planned under PHCF:

- Implementation of Public Health Challenge Fund activities
- Capacity building of Village Health Sanitation Committee (VHSC) and Arogya Raksha Samithi (ARS)
- Quality Management of hospitals
- Liquid Waste Management Consultancy – For implementation of Liquid Waste Management in the hospitals.
- Health Care Waste Management Cell – Creation of Health Care Waste Management Cell for the implementation and monitoring of waste management.

### **Health Financing Insurance):**

**362.** Suvarna Arogya Suraksha Health Insurance Scheme is implemented in Karnataka which covers tertiary care services for all the SC/ST and BPL families in the State which is launched for Gulbarga Division during the current year. A portion of the premium for the beneficiaries will be paid from the project funds. Training and workshops for State level and district level are planned and also third party evaluation is planned for the next year.

### **Monitoring & Evaluation:**

**363.** The monitoring mechanism is developed at various levels for all the programmes starting from State level to the PHC level. The State Project Management Unit at the State level will be responsible for implementation and monitoring of the programme. The SPMU is headed by the Project Administrator who will be assisted by a team of technical and administrative personnel along with inhouse consultants. At the district level, the District Health & FW Officer will head the district and he is supported by the District Project Management Unit. The apex body to take policy decision for implementation of KHSDRP is the Project Governing Board headed by the Chief Secretary to the

Government of Karnataka. The Programme Steering Committee under the chairmanship of the Principal Secretary to Government, Health & FW Dept. will monitor the progress of the programme.

**364.** The basic objective is to effect the change in the existing set-up rather than creating a new parallel unit. The SPMU will not function as a stand-alone entity, but will work in close co-ordination with other departments of Health & FW Services. The Health Management Information System is developed for the Department, which will monitor the progress of the programmes.

- Software has been developed for Health Management Information System which includes **Performance Indicator reports, Man power details, Non-clinical details and Equipment Monitoring System.**
- Initially, Tumkur district has been taken up for testing purpose and completed successfully. The training is completed for district level, taluk level and CHCs to make the performance indicators web enabled.
- GIS has been developed and hosted. Under GIS Mapping, two layers have been incorporated i) Area marking for PHCs, Sub-centres, taluks and districts for the purpose of programme management.  
ii) Static and Semi-static data is attached as a second layer and is successfully implemented for all the districts. GIS Mapping is completed for all the 29 districts in the State and the Static and Semi-static data for all the 29 districts is completed and validation is also completed. GIS is made web enabled.
- Organisation Unit upto PHC level for 29 districts is completed in DHIS-2 software. Training is completed for all the districts to implement DHIS-2 and the data is already fed district-wise from April to December, 2008. The PHC-wise data entry is started at the district level from January 2009. The PHC level data entry is initiated at taluk level from April 2009. **Dash board analysis is introduced from which any data element and indicators can be analysed by using dash board option.**
- Software is developed with the help of NIC for equipment management under the name of Health Management Information System.
- HMIS web enabled training has already been started in all the districts of the State to cover district hospital, taluk hospitals, sub-divisional hospitals and community health centres. The training is completed for district level hospitals as well as taluk level hospitals and CHCs in 29 districts in the State.
- DHIS-2 training is completed for district level officers viz., DHO, DPMO, RCH, ASOs of all 29 districts. Re-orientation training is also conducted.
- Training is conducted for the medical officers, programme officers, staff nurse, pharmacists and data entry operators in all the 29 districts for HMIS and DHIS2.
- GIS Map licensing procured and installed.
- The final report of Baseline Survey is received and final payment is under process. Additional analysis awaited from M/s. PRC, Dharwad.

**365.** The following activities are planned for the next year:

**A. Further development of application system**

1. Hospital MIS – Query reports and grading of hospitals
2. GIS – Additional requirements from department, validation of data and updation of data
3. DHIS2 – Integration of National Programmes – Malaria, Leprosy, IDSP and initiation of sub-centre level data feeding
4. Networking of District Hospitals and State Health Informatics Centre

**B. Procurement of Equipment, Computers and others**

1. Servers to State headquarters (creating web server, hosting capacity)
2. Generator and UPS
3. Desktop computers to computer centre
4. Computer to PHCs and CHCs
5. Production of training modules, manuals and materials
6. Procurement of computers and accessories to the programme officers
7. Printing of HMIS formats
8. Books and periodicals to ANM training centres
9. Procurement of PCs and accessories and laptops for districts
10. Furniture and equipment to State Health Informatics Centre

**C. Training and capacity building**

1. Basic computer and HMIS software training to health staff (ongoing)
2. Capacity building and training for the DHOs and district programme officers
3. Training for newly recruited IT staff at New Delhi
4. Training programme for programme officers in HMIS

**D. Manpower**

1. Creation of IT post (Junior Programmer) at district level by redeployment process in 29 districts and Data Entry Operators (Gr.I) by redeployment process (taluk level)

**E. Beneficiary Tracking System**

1. Agreement of beneficiary register
2. Database creation
3. ANM register automation
4. Reports created – workplan, alerts/reminders

**F. Beneficiary verification system**

1. Field visit for requirement gathering
2. Discussion and agreement on pilot
3. Software development for the above
4. Initiation of pilot
5. Evaluation of the pilot

**366. Evaluation:**

- Base-line, mid-project and end-project surveys are planned
- Household and Facility surveys are planned
- Third party evaluation for PPP activities and departmental schemes (Mobile Health Clinic, Arogya Bandhu Scheme, Citizen Helpdesk, Tyayi Bhagya scheme) are planned.



**Table : 72 - PROGRAMME PLAN FOR THE REMAINING 3 YEARS OF THE PROJECT**

<b>COMPONENT-Organisation Development - Dr. S.M. Sridhar - Head of Account 2210-06-800-0-81</b>											<b>18/12/2009</b>
<b>Activities planned</b>	<b>Allocations as per pad</b>				<b>Cumulative expenditure till 31-03-09</b>	<b>Balance (PAD allocation-expenditure till 2008-09)</b>	<b>Estimates for 2009-10</b>	<b>Estimates for 2010-11</b>	<b>Rs. In lakhs</b>		<b>Remarks</b>
									<b>Estimates for 2011-12</b>	<b>Balance</b>	
	<b>2204.4</b>				<b>237.85</b>	<b>1966.55</b>	<b>225</b>	<b>937.4</b>	<b>766.6</b>	<b>37.55</b>	
	<b>Unit of measure</b>	<b>Unit cost</b>	<b>Estimated cost</b>	<b>Contract value</b>							
Co-ordination Meetings			5				1.0	2.0	2.0		
Best Practices			9					5.4	3.6		
<b>Strengthening of Cells.</b>											
PPP Cell			25				5.0	10.0	10.0		
Health Accounts - Finance Cell			40				8.0	16.0	16.0		
Health Care Waste Management Cell			60				12.0	24.0	24.0		
Quality Assurance Cell			40				8.0	16.0	16.0		
Blood bank Cell			40				8.0	16.0	16.0		
IEC Cell			100				5.0	50.0	45.0		
<b>Study tours</b>			40					24.0	16.0		
<b>Capacity Building</b>											
Personality Development/Distant Education courses/soft skill development for Doctors			80				10.0	38.0	32.0		

Behaviour and Attitudinal Change workshop for Medical, Paramedical, Ministerial and Group D staff			1075				100.0	545.0	430.0		
<b>OD Consultancy</b>											
i. Embedding Leadership Excellence in Doctors – SSS **** i) consultancies - 2 ii) Training/logistics etc.			175				20.0	85.0	70.0		
ii. OD initiatives – SSS **** i) consultancies - 2 ii) Training/logistics etc.			100				20.0	50.0	30.0		
<b>Other OD Activities</b>			30				6.0	12.0	12.0		
<b>Strengthening SIHFW</b>			110				22.0	44.0	44.0		
<b>Total</b>		<b>0</b>	<b>1929</b>				<b>225.0</b>	<b>937.4</b>	<b>766.6</b>		

Table-73

PROGRAMME PLAN FOR THE REMAINING 3 YEARS OF THE PROJECT											
COMPONENT-Organisation Development - Dr. S.M. Sridhar - Head of Account 2210-06-800-0-81								18/12/2009			
									Rs. In lakhs		
Activities planned	Allocations as per pad				Cumulative expenditure till 31-03-09	Balance (PAD allocation-expenditure till 2008-09)	Estimates for 2009-10	Estimates for 2010-11	Estimates for 2011-12	Balance	Remarks
	2204.4				237.85	1966.55	225	937.4	766.6	37.55	
	Unit of measure	Unit cost	Estimated cost	Contract value							
Co-ordination Meetings			5				1.0	2.0	2.0		
Best Practices			9					5.4	3.6		
<b>Strengthening of Cells.</b>											
PPP Cell			25				5.0	10.0	10.0		
Health Accounts - Finance Cell			40				8.0	16.0	16.0		
Health Care Waste Management Cell			60				12.0	24.0	24.0		
Quality Assurance Cell			40				8.0	16.0	16.0		
Blood bank Cell			40				8.0	16.0	16.0		
IEC Cell			100				5.0	50.0	45.0		
<b>Study tours</b>			40					24.0	16.0		
<b>Capacity Building</b>											
Personality Development/Distant Education courses/soft skill development for Doctors			80				10.0	38.0	32.0		
Behaviour and Attitudinal Change workshop for Medical, Paramedical, Ministerial and Group D staff			1075				100.0	545.0	430.0		
<b>OD Consultancy</b>											



Table-75

Health Financing - Dr. G.Y. Nagaraj - Head of Account 2210-06-800-0-8328/					18/12/2009						
<b>Health Financing</b>	<b>4456.7</b>				<b>93.53</b>	<b>4363.17</b>	<b>766</b>	<b>1207.39</b>	<b>2389.78</b>		
<b>Activities planned</b>	<b>Unit of measure</b>	<b>Unit cost</b>	<b>Estimated cost</b>	<b>Contract value</b>							
1. Health insurance consultancy ( 18 Lakhs)			18					6	6		
2. Health Insurance premium at the rate of Rs./- 300 per beneficial			4301.17				766	1176.39	2358.78		
	Training										
3. Third party evaluation	Evaluation		50					25	25		
<b>Total</b>			<b>4369.17</b>				<b>766</b>	<b>1207.39</b>	<b>2389.78</b>		

Table-76

Monitoring & Evaluation - Dr. B.G. Prakash Kumar - Head of Account 2210-06-800-0-84 (Revenue Account)					18/12/2009						
<b>Monitoring &amp; Evaluation</b>	<b>4287.2</b>				<b>1653.16</b>	<b>2634.04</b>	<b>1142.19</b>	<b>1867.77</b>	<b>1932.50</b>	<b>-2308.42</b>	
<b>Activities planned</b>	<b>Unit of measure</b>	<b>Unit cost</b>	<b>Estimated cost</b>	<b>Contract value</b>							
Award of Contract for IT / NIC Support	Consultancy	0.20	60.00				20.00	20.00	20.00		
Training of Health Staff (one day training, two days training, 1 week training and 3 days training which includes hardware and software training)	Training		176.00				96.00	20.00	60.00		
GIS mapping licensing	Licensing	1	8.50								Procured in 2nd year
Baseline Survey	Survey	1	16.20								Completed in 2nd year
Production of training modules, manuals and materials	manuals production		14.00					9.00	5.00		

Networking & Computerisation of District Hospitals and State Health Informatics Centre	Networking		146.00				80.00	66.00		
Procurement of computers and accessories to the programme officers	Computers	0.45	26.75			26.75				
Printing of HMIS formats	HMIS Formats		10.00			10.00				
Training programme for programme officers in HMIS	Training		4.00			4.00				
Books and periodicals to ANM Training Centres	Books		2.00				2.00			
Procurement of PC & Accessories and Laptops for the districts (DHO/DPMO, District Program Officer and ASO)	Computers		22.00			22.00				
Procurement of Computers and accessories to PHCs	Computers	0.7	25.00				25.00			
Creation of IT Post (Jr. Programmer at Dist. Level by redeployment process) in 29 districts and Data Entry Operator (Gr.I) by redeployment process										
Establishing HCWM Cell	2 SNOE, DNOE, 28 HCWM Officers		340			20	161	159		Dr. Murali Krishna
NABH/NABL Consultancy			1080.00			0	540.00	540.00		Dr. Murali Krishna
Salary	Project Staff		2275.67			428.6	470.2	514.9		
Others (Travel, general, telephone, building expenses, transport etc.)			2351.46			514.8	540.6	567.6		
Liquid Waste Management Consultancy										
Total			6557.58			1142.19	1867.77	1932.50		

Table-77

Public Private Partnership & Tribal Health Care Services - Dr. G.Y Nagaraj - 2210-06-800-0-85										18/12/2009	
PPP & TBHC S	8204.7				109.28	8095.42	535	3652	3722	186.42	
Taayi Bhagya Scheme	6C Dist. & Chamr.		2670					1370	1370		
Mobile Health Clinic Phase-I- 5, Mobile Health Clinic Phase-II- 14, Mobile Health Clinic Phase-III- 11	60 MHCs	1.25	2700				400	1150	1150		
Regional Diagnostic Laboratories	3 RDL	2.5	270				30	120	120		
Contracting in Specialist Service	specialists	0.25	675.00				50.00	310	315		
Arogya Bandhu Phase I-10, PhaseII-10, Phase III-10	20 PHCs		540.00					170	370		
Establishing Citizen Help Desk	10 Dist.Hosl.	0.6	228.00				24	102	102.00		
Contracting in Non-clinical services for PHC (Housekeeping services)	100 PHCs	0.20	566.00				6.00	280	280		
Training for Grass root level, MHC, RDL, CHD, Arogya Bandhu	Training		25.00				5.00	15	5		
Procuring materials for Model Health Waste Management Hospitals	6 Hospitals	20.00	120.00				20.00	100			Dr. Murali Krishna
Training for 450 members	Training		45.00					35	10		Dr. Murali Krishna
<b>Total</b>			<b>7839</b>				<b>535</b>	<b>3652</b>	<b>3722</b>		

Machinery & Equipment - Dr. B.G. Prakash Kumar & Procurement Section - Head of Account 4210-01-110-186										18/12/2009
	2304.5				201.97	2102.53	92	869		*1141.53
Activities planned	Unit of measure	Unit cost	Estimated cost	Contract value						
Servers to State Head quarters	Servers		37.50				37.50			
Generator and UPS	Ge & UPS		50.00				50.00			
Furniture to State Health Informatics Centre	Furniture		5.00					5.00		
Equipment to State Health Informatics Centre	Equipment		25.00					25.00		
	Computers	0.7	339.00					339.00		
Desktop computers to Computer Centre	Computers	0.45	4.50				4.50			
Computers to Taluk Health Officers-176	Computers									procured under NRHM
Computer to PHCs/CHCs	Computers		500.00					500.00		
							92.00	869.00		

\* Note: Saving amount will be utilised for Management & Evaluation for Revenue Component.

Service Improvement Challenge Fund - Dr. B.G. Prakash Kumar - Head of Account 4210-01-110-1-87										18/12/2009
	*16492				4575.38	11916.62	3246.45	7307.5	1183	
Activities planned	Unit of measure	Unit cost	Estimated cost	Contract value						
<b>Infrastructure - Constructions</b>										
Construction of 35 PHC complexes	35 PHCs		3302.82	4817.54	1599.16		1449.96	1768.42		Spill over for 2009-10 & new PHC & SC construction depending
Construction of 152 ANM Sub-centres	152 Sub-centres		2628.96	2885.93	2013.99		98.36	773.58		

Construction of 9 ANM Training Centres	9 ANMTCs		1521.00	1542.86	249.02		759.22	534.62			upon the budget availability
Construction of Drug Warehouses-13	13 Warehouses		1792.00	2112.52			348.65	1398.88			
Construction of State Health Informatics Centre (SHIC)-1	1 SHIC		500.00	500				67	433.00		
Construction of quarters for 24X7 PHCs-40	24X7 PHCs-20 qrts.	20.00	800.00				200.00	400	200		
Creation of model 24X7 PHCs-70	24X7 PHCs-30 model	10.00	700.00				100.00	600			
Addition/alteration and repair of DPMOs' buildings-17	17 DPMOs		47.79	41.79	30.53		11.26				
Strengthening of State Food lab and 3 regional food labs	1+3 labs	15.00	260.00				60.00	200			
Renovation/Repairs of PHCs/CHCs/Sub-centres in 10 districts	58 facilities in 10 districts		682.68	682.68	682.68						
Repair and renovation of ANMTCs-19	19 ANMTCs	26.32	500.00					500			
Repair and renovation of RH&FWTCs-4	4 RH&FWTCs	31.25	125.00					125			
Equipment to newly constructed PHCs	Equipment		140.00				140.00				
Equipment to newly constructed ANM Sub-centres	Equipment		32.40				32.40				
Equipment to State and 3 regional food labs	Equipment		8.00					8.00			
Equipment to 9 ANM Training Centres	Equipment	5.00	45.00					45.00			
Equipment to Drug Warehouses	Equipment	2.00	26.00					26.00			

Equipment to creation of model 24X7 PHCs	Equipment		28.00				28.00			
Furniture to newly constructed PHCs	Furniture		25.00			25.00				
Furniture to newly constructed ANM Sub-centres	Furniture		21.60			21.6				
Furniture to State and 3 regional food labs	Furniture		8.00				8.00			
Furniture to 9 ANM Training Centers	Furniture	5.00	45.00				45.00			
Furniture to Drug Warehouses	Furniture	2.00	26.00				26.00			
Furniture to creation of model 24X7 PHCs	Furniture		4.00				4.00			
Establishment of Liquid Waste Management	10 Hospitals	85	600.00	600.00			400	200		
NABH/NABL Gap work, civil & others		35	700.00	700.00			0.00	350	350	
					4575.38		<b>3246.45</b>	<b>7307.50</b>	<b>1183</b>	

\* Rs. 16492 lakhs amount includes price & physical contingency of Rs. 3795.80 lakhs

## **CHAPTER-36**

### **Vulnerable Community Plan of the Seven Focussed Districts**

**(as identified by Governement of India)**

**367.**Seven district have been identified as focussed districts by Government of India based on several parameters as percentage of SC/ST population in the community and other 13 indicators as per DLHS-3, as low standard of living , early marriage, low institutional delivery, female literacy, housing, immunization etc. These districts are Bidar, Bellary, Raichur, Davanagere, Chitradurga, Kolar and Chamarajanagara.

**368.**One of the priority areas for action during the year 2010-11 is prioritising care for the vulnerable communities residing in the unserved areas and underserved areas. These population mainly belong to the scheduled caste and scheduled tribes. The health indicators in these communities are low as they do not have proper access to health facilities. The state health indicators cannot be improved unless the health indicators of these communities improve.

#### **Vulunerble community plan of the seven focussed districts**

**(as identified by Government of India) is complied and submitted for persual.**

F. No. 10(10) 2010 NRHM-I

Government of India

Ministry of Health & Family Welfare

Department of Health & Family Welfare

Nirman Bhawan, New Delhi

Dated: 29<sup>th</sup> April 2010

To,

The Mission Director, (NRHM)

Government of Karnataka

Directorate of Health & FW services,

3<sup>rd</sup> Floor, IPP Building,

Anand Rao Circle,

Bengaluru

Subject: Approval of State Programme Implementation Plan of NRHM for the year 2010-11

Madam/Sir,

Please refer to your letter submitting draft Programme Implementation Plan (PIP) for the year 2010-11 and the discussions of the same in the meeting of NPCC held on 09/02/2010 at New Delhi and subsequent deliberations<sup>1</sup>.

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<sup>1</sup>.Budgets may be realigned within 3 months of the issue of the Order, to achieve Monitorable Targets indicated in Attachment F, in case there has been inadequate provision in the PIP, to meet national goals.

2. The administrative approval of the PIP for your State is conveyed for an amount of **Rs. 856.94 Cr.** (Rupees Eight Hundred Fifty Six Crore and Ninety Four Lakh only) (Detail at Table C below) against the resource envelope available comprising of the following:-

**Table A**

Likely Uncommitted Unspent Balance Available under NRHM as on 1.4.2010	Rs. 135.00 Cr.
GOI Resource Envelope for 2010-11 under NRHM (on a 15% higher than current year's Budget Estimate for over planning purpose) <sup>2</sup>	Rs. 634.12 Cr.
15% State share	Rs. 97.31 Cr.
<b>Total</b>	<b>Rs. 866.43 Cr.</b>

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*2. The actual resource allocation shall be in accordance with the budgetary allocation of 2010-11 and may be lower than the resource envelope being approved*

The Resource Pool wise break up of total NRHM resources is as follows:

(Rs. in Crores)

**Table B**

Sl No.		Likely Uncommitted Unspent balance available as on 1.4.2010	GoI Resource Envelope under NRHM	Total
1	RCH Flexible Pool	Rs. 40.00 Cr.	Rs. 156.30 Cr.	Rs.196.30 Cr.
2	NRHM Flexible Pool	Rs. 70.00 Cr.	Rs. 164.15 Cr.	Rs 234.15 Cr.
3	Immunization ( from RCH Flexible Pool)			
4	NVBDCP	Rs. 2.00 Cr.	Rs. 4.31 Cr.	Rs. 6.31 Cr.
5	RNTCP	Rs. 1.00 Cr.	Rs. 14.87 Cr.	Rs. 15.87 Cr.
6	NPCB	Rs. 1.50 Cr.	Rs. 12.97 Cr.	Rs. 14.47 Cr.
7	NLEP	Rs. 0.25 Cr.	Rs. 1.70 Cr	Rs. 1.95 Cr
8	IDSP	Rs. 0.25 Cr.	Rs. 1.34 Cr.	Rs. 1.59 Cr.
9	NIDDCP	Nil	Rs. 0.24 Cr	Rs. 0.24 Cr
10	Director & Admn. (Treasury route)	Nil	Rs. 185.62 Cr.	Rs. 185.62 Cr.
11	PPI Oper. Cost	Nil	Rs. 9.91 Cr	Rs.9.91 Cr
12	15% State share	Rs. 20.00 Cr.	Rs. 97.31 Cr	Rs. 117.31 Cr
13	15% over and above GoI resource envelope for purpose of PIP approval	Nil	Rs. 82.71 Cr	RS. 82.71 Cr

	<b>Total</b>	<b>Rs. 135.00 Cr.</b>	<b>Rs.731.43 Cr.</b>	<b>Rs. 866.43 Cr.</b>
	<b>Committed Unspent Balance up to 2009-10 to be Revalidated in 2010-11</b>	<b>Rs. 25.00 Crore</b>		

### SUMMARY OF APPROVAL

(Details provided in respective Annexes)

**Table C**

	Scheme/Programme	Approved Amount ( In Rs. Crores)
1.	RCH Flexible Pool (Details at Attachment A)	230.13
2.	NRHM Mission Flexible Pool (Details at Attachment B)	396.51
3.	Immunization ( from the RCH Flexible Pool) (Details at Attachment C)	6.51
4.	NVBDCP (Details at Attachment D)	3.74
5.	RNTCP (Details at Attachment D)	14.91
6.	NPCB (Details at Attachment D)	12.96
7.	NIDDCP	0.24

	(Details at Attachment D)	
8.	IDSP (Details at Attachment D)	1.70
9.	NLEP (Details at Attachment D)	2.94
10	PPI Operation Cost	1.70
11	Infrastructure Maintenance	185.6
	<b>TOTAL</b>	<b>856.94</b>

In addition to above following activities under NPPCD for provisioning of funding from National Programme for Prevention and Control of Deafness.

	Scheme/Programme	Approved Amount ( In Rs. Crores)
12	NPPCD (Details at Attachment E)	2.79

**3. The above approval is subject to the following mandatory requirements. Non compliance to any of the following requirement may entail in suspension of grant to the State.**

**A. Monitoring Requirements**

1. State/UT shall ensure submission of quarterly report on Measurable Target/indicators at the end of every quarter as per Attachment F and expected outputs stated in the Record of Proceeding in Annexures of Attachment G. Budgets may be realigned within 3 months of the issue of the Order to achieve Monitorable Targets indicated in Attachment F in case there has been inadequate provision in the PIP, to meet national goals,
2. All approvals are subject to the observations made in the RoP of NPCC for NRHM (Attachment G) which is inclusive of commodity grants under Disease Control Programme in the respective Annexures.

**B. Human Resource**

3. All Posts under NRHM shall be on contract and for the Plan period. All such appointments would be for a particular facility and non transferable in nature. Priority in contractual recruitments and placements would be for backward districts, difficult, most difficult and inaccessible health facilities.
4. All States would ensure that appropriate skill mix of human resource is made available to ensure provision of minimum service guarantee to health facilities. All professionals multi skilled under NRHM shall be placed in facilities where the skills can be utilized.
5. State shall submit action plan for recruitment, deployment and training of human resources within six months from the issue of the Order.

**C. Infrastructure**

6. All civil works undertaken to achieve IPHS standards, would be based on expected patient load and priority would be accorded to inaccessible and remote areas as per prescribed criteria.
7. In all new constructions, care should be taken to ensure that the location of these facilities are such that beneficiary households can access them easily. They should preferably be located in the midst of habitation and definitely not in agriculture fields, and outskirts of villages, under any circumstances. Any deviation from the above would be treated as ineligible expenditure under NRHM.
8. All new constructions would require prior approval of GoI if names of facilities have not been mentioned in the NRHM-PIP, and also if any shift is proposed. No shift from backward and inaccessible areas would be allowed.
9. The State shall set up implementation arrangement to monitor all civil works being undertaken, on a monthly basis, to ensure quality of works and completion as per schedule.

**D. Communitization**

10. The State shall ensure that all operational guidelines relating to VH&NDs are complied with.
11. The State shall ensure timely performance based payments to ASHAs/Community Link Workers. State to ensure that supportive supervision mechanism is put in place within six months.
12. The State shall ensure that RKS meets as frequently as possible and mandatorily at least once in every quarter to review proper utilisation of allocated funds for achievement of goals. The proceedings of such meetings should be maintained for scrutiny.

**E. Financial**

13. The State shall not make any change in allocation among different components/ activities without approval of GoI. Any proposal for re-appropriation between activities within activities should be informed to GoI in advance. However, such re-appropriation should reflect realignment of activities in accordance with priority to high focus districts/involvement of NGOs etc.
14. The State shall ensure that 15% of the State share, based on release of funds by Government of India is credited to the account of the State Health Society, within one month of issue of the release order. The over-all expenditure on health by the State Government should also go up by a minimum of 10 percent each year.
15. The State shall ensure the completion of delegation of administrative and financial powers during the current financial year. Funding of NRHM to the State in 2010-2011 will be based on clear delegation as per earlier directions.
16. The State shall follow all the financial management systems under operation under NRHM and shall submit Audit Reports, Quarterly Summary Concurrent Audit Report, FMRs, Statement of Fund Position, as and when they are due. State also agrees to undertake Monthly District Audit and periodic assessment of the financial system.
17. The accounts of the State/ grantee institution/ organization shall be open to inspection by the sanctioning authority and audit by the Comptroller and Auditor General of India under the provisions of CAG (DPC) Act 1971 and internal audit by Principal Accounts Office of the Ministry of Health & Family Welfare.
18. State shall ensure submission of details of unspent balance indicating, inter alia, funds released in advance and funds available under State Health Societies. The State shall also intimate the interest amount earned on unspent balance. This amount can be spent against activities already approved and will also count towards the central share.

**F. Miscellaneous**

19. The State shall ensure establishment of supportive supervisory structures for RCH and other national programmes in lagging districts and for ensuring quality services, within six months of the issue of the Order.
20. The State shall maintain essential drug list /develop Standard Protocols , and enforce its implementation through State machinery.
21. Component for the salary of staff and mobility support which is being approved in IDSP Annexure would be subject to approval of EPC/MSG under NRHM. The support for

expenditure to be incurred by Central Surveillance Unit (CSU) and the State is subject to approval of World Bank for restructuring and Extension.

22. State shall ensure taking appropriate action to monitor the performance of the cold chain /ILR Points and implementation details of ProMIS.

Yours faithfully

(P.K. Bali)

Under Secretary to the Government of India

Copy to:

1. All JSs in the Ministry of Health & FW
1. All Programme Division Heads of NRHM/ RCH/ Disease Control Programmes
2. DS/Director Finance (NRHM)
3. All Under Secretaries concerned
4. IFD
5. PPS to Secretary(H&FW)/PS to AS&MD, NRHM
6. Sanction Folder

APPROVAL OF RCH-II PIP 2010-11

(Rs. in lakh )

S.No	ACTIVITY	APPROVED AMOUNT	"MAJOR" EXPECTED OUTPUT AS PER PIP
1	Maternal Health	10.62	Review of 1250 maternal deaths
2	JSY	4602.58	48964 Home Delivery beneficiaries, 250000 Rural beneficiaries, 131427 Urban Beneficiaries, 48680 cesarian deliveries beneficiaries, ASHA incentive for (3 tribal districts) - 10000 ASHAs & incentive for (other districts) - 425000 ASHA
3	Child Health	427.50	FBNC for 3000 cases, Review of ASHA performance in 7 districts & Running costs of 2 NRCs; Retinopathy project in 5 districts
4	Family Planning	5446.29	10000 manuals on sterilisation standards & QA of sterilisation services, 2000 female sterilisation camps, For 50 laparoscopes, for 30 QA meetings & 1.00 lakhs beneficiaries to be covered by ASHA for follow up of IUD insertion. 1000 NSV camps, 355275 female and 10000 male sterilisation cases, 308250 IUD insertions
5	ARSH	135.00	Setting up 45 Adolescent services at health facilities
6	Urban RCH	480.73	Salary of 58 MOs and 425 ANMs
7	Vulnerable Groups	263.00	Activities for 7 districts
8	Innovations / PPP/ NGO	287.50	State level workshop, quarterly Taluk level workshops & Grant-in-Aid to 14 NGOs
9	Infrastructure & HR	6276.29	447 ANMs + 20 ANMs in tribal area, 98 LTs, 4550 SNs, 75 Doctors, 200 MOs; 105 contractual staff for CH (NICU), Remote area allowance; Incentive to ASHA for 179167 non-JSY beneficiaries (ANC registration, 3 ANC, 100 IFA tablets, 2 TT, 6 PNC visits, accompanying the pregnant women for institutional delivery and staying with them).
10	Institutional Strengthening	491.34	Computer consumables, LAN, computer training, Printing of 20000 registers, Printing of 8.60 lakhs HMIS forms, Training of 196 staff in HMIS, Quality assurance to be implemented in 18 districts

11	Training	1743.00	Strengthening 25 training centres, SBA for 500 MOs in 100 batches, 500 SN in 190 batches and 900 ANM's in 300 batches , EMOc of 48 MO's in 6 batches, Anaesthesia of 28 MO's in 7 batches, MTP of 32 in 16 batches, RTI/STI Training of 1650 MO+LT+SN), IMEP of 1700 (MO+SN), IMNCI of 6450 (MO, SN, ANM/ LHV, AWW), HBNBC of 6962 (ASHA TOT's and ASHA), Other CH for 3840 (MO and SN from district hospitals and SN of PHC), FP in 30 batches, 60 batches, 300 MO's, 5400 (MOs, SNs, LHVs, ANMs), ARSH for 4500 (MOs, SNs, ANMs), DPMU
12	BCC/ IEC	780.00	Sensitization workshops on RCH Issues; BCC / IEC strategies at all levels; production of IEC Materials on RCH Themes to inculcate / develop / sustain healthy behaviour.
13	Procurement	1229.56	Lab Reagents, RTI/STI kits, IFA tabs, CHC kits drugs and reagents
14	Program Management	840.57	Strengthening of State society/SPMU/DPMU/ District Society/financial management
<b>GRAND TOTAL RCH II</b>		<b>23013.98</b>	

**Attachment- B**

**APPROVAL OF MISSION FLEXI POOL**

(Rs. in lakh)

S.NO	ACTIVITY	APPROVED AMOUNT	"MAJOR" EXPECTED OUTPUT AS PER PIP
1	ASHA	942.5	1000 ASHA selected, 15000 ASHA with Drug kits,100% ASHA's account opened , 23000 bags purchased & distributed, training 9000 ASHA
2	Untied Funds	4487.15	324 CHC, 2193 PHC, 8143 SHC , 29406 VHSC & 44 UHC , to strengthen the quality
3	Annual Maintenance Grants	1830.7	324 CHCs, 19 ANMTC, 1955 PHCs, 5102 SHC to strengthen the quality as per IPHS standard.
4	New Constructions/ Renovation and Setting	7000.00	9 FRU, 4 ANMTC (CHC) , 94 PHC, 85 SHC, 100 new PHC, 300 new SHC & 5 MCH.

5	Corpus Grants to HMS/RKS	2602.00	17 DH, 178 CHC, 146 Taluka Hospitals & 2193PHC.
6	District Health Action Plans (Including Block, Village)	35.00	29 DAPS
7	Panchayati initiative	1350.00	Capacity building of PRIs and RKS members
8	Mainstreaming of AYUSH	1300.00	500 old and 140 new Doctor's salary, 2 Doctors Yoga and Natroopathy, 2 PG Doctors, 300 paramedical Staff,IEC, Training of 200 Doctors
9	Mobile Medical Units	450.00	30 MMU @ Rs. 15 lacs
10	Referral Transport	9602.00	92 ALS @Rs.18.40 lakhs & 275 BLS @ Rs.12.40 lakhs & recurring cost for 517 EMRI.
11	School Health Programme (Suvarna Arogya Chaitanya)	1100.00	Medical Examination, Training/Meeting/Workshops/IEC. Health promotion activities, transportation and M&E
12	Contractual Staff (Selection, Training, Remuneration)	874.35	Recurring cost for 384 drivers & 751 ANM recruited in 6C districts. 750 ANM
13	Training	25.00	Training held, personnel trained
14	Incentives Schemes	3266.6	Training held, personnel trained (base not mentioned in PIP), Kits to BPL/SC/ST women procured and distributed & facilities integrated 83 ICTCs located in PHCs & further details in ROP.
15	Planning, Implementation and Monitoring	55.00	Community Monitoring activities in 30 districts in place (workshops at state, Dist, Block level)
16	Procurements of Drugs & Equipments	2115.67	94 PHCs & 138 SCs upgraded as IPHS norms.
17	Health Insurance Scheme	60.00	1000 beneficiaries insured.
18	Research, Studies, Analysis	269.64	Analysis, report submission and dissemination
19	State level health resources center(SHSRC	50.00	Merging of health resource centre and NRHM personnel recruited
20	NRHM Management Costs	895.80	BPM 176, BAA 176, data entry operators 176

21	Other Expenditures	1340.31	9 new ANMTCs, Rs.36 lakhs for civil works, Rs. 10 lakhs for 50 microscopes, 5 LTs at STDC, Help Desk at 20 DH @ Rs. 8.40 lacs & Rs. 20.00 lakhs for Anti-tobacco campaign
<b>TOTAL</b>		<b>39651.72</b>	

**Attachment- C**

**APPROVAL OF IMMUNIZATION STRENGTHENING PROGRAMME**

(Rs. in lakh)

S. NO.	ACTIVITIES	APPROVED AMOUNT	"MAJOR" EXPECTED OUTPUT AS PER PIP
1	Mobility support for Supervision and Monitoring at districts and state level.	14.50	Improved supervision of programme.
2	Cold chain maintenance	25.94	Strengthening of Cold Chain.
3	Alternate Vaccine Delivery to Session sites	132.24	
4	Focus on urban slum & underserved areas	63.46	
5	Social Mobilization by ASHA /Link workers	281.47	
6	Computer Assistants support at State& district level	34.80	
7	Printing and dissemination of immunization cards, tally sheets, charts, registers, receipt book, monitoring formats etc.	49.00	Strengthening & Monitoring
8	Quarterly review meeting at state and Block	19.50	Regular meetings for programme review

9	Three days training of Mos on RI	14.50	
10	One day cold chain handlers trainings	8.70	
11	POL for vaccine delivery from state to District and PHC/CHCs	7.80	
<b>TOTAL</b>		<b>651.91</b>	

**Attachment- D**

**APPROVAL OF RNTCP**

(Rs. in lakh)

S. NO.	ACTIVITIES	APPROVED AMOUNT	"MAJOR" EXPECTED OUTPUT AS PER PIP
1	Civil works	23.00	1) Civil work Upgradation and maintenance to complete as planned
3	Honorarium/Contractual services	825.00	1) All eligible Community DOT Providers are paid honorarium in all districts in the FY; Contractual staff .
4	IEC/ Publicity/Printing	80.00	1) All IEC/ACSM activities to be completed; 2) Increase in case detection and improved case holding
5	Procurement and Equipment maintenance/Laboratory materials	125.00	1) Maintenance of Office Equipments at State/Districts and IRL equipments completed as planned; 2) All BMs are in functional condition; 3) Sputum of TB Suspects Examination per lac population per quarter; 2) All districts subjecte to IRL OSE and Panel Testing in the year; 3) IRLs accredited and functioning optimally;
6	Training	80.00	1) Induction training, Update and Re-training of all cadre of staff.
7	Vehicle	89.00	1) All 4 wheelers and 2 wheelers in the state running in good condition and maintained;

	maintenance/hiring		Increase in supervisory visit of DTOs and MOTCs
9	NGO/PP support	60.00	1) Increase in number of NGOs/PPs involved in signed schemes of RNTCP; 2) Contribution of NGOs/PPS in case detection and provision of DOT
10	Miscellaneous	109.00	1) All activities proposed under miscellaneous head in PIP completed; Proposed Research done.
14	Medical Colleges	100.00	1) All activities proposed under Medical Colleges head in PIP to be completed;
<b>TOTAL</b>		<b>1491.00</b>	

**APPROVAL OF NVBDCP**

(Rs.in lakh)

S. NO.	ACTIVITIES	APPROVED AMOUNT	"MAJOR" EXPECTED OUTPUT AS PER PIP
1	Malaria (DBS)	135.75	Improved surveillance, capacity of MPWs, ASHAs & Mos, social mobilization and awareness generation
2	Filaria	80.00	Elimination of Lymphatic Filariasis - preparatory activities coordination committee meetings, training, mopping up operations, transport, night blood survey and M&E Timely completion and observance of MDA with improved drug compliance
3	Dengue & Chikungunya	52.00	Early diagnosis & treatment to reduce case fatality rate, improved capacity of medical and para medicals, quick reporting
4	AES/JE	17.00	Improved capacity of medical and para medicals, early diagnosis & treatment to reduce case fatality rate ,fogging to affected area in outbreaks

5	Decentralised drugs & larvicides (DBS)	89.46	No shortage of drugs
6	<b>Total cash assistance including cost of decentralized commodities</b>	<b>374.21</b>	
7	<b>Commodity support by GoI for VBD</b>	<b>163.20</b>	
<b>Grand Total cash + commodity</b>		<b>537.41</b>	

**APPROVAL OF IDSP**

(Rs. in lakh)

S. No.	ACTIVITY	APPROVED AMOUNT	"MAJOR" EXPECTED OUTPUT AS PER PIP
1.	Surveillance preparedness, training & staff salary	294.00	Training of professionals (DSO, Epidemiologists, Microbiologists, Entomologists)
	Outbreak investigation		2. IT network for transmission of data and outbreak reporting
2.	Analysis & use of data		3. Strengthening of lab.
			4. Surveillance and reporting of disease outbreaks
3.			5. Strengthening of AI surveillance
<b>TOTAL</b>		<b>294.00</b>	

**APPROVAL OF NPCB**

(Rs. in lakh)

S. No.	ACTIVITY	APPROVED AMOUNT	"MAJOR" EXPECTED OUTPUT AS PER PIP
1	Cataract Surgery	1200.00	4000000 cataract surgeries.
2	Training	40.00	
3	Contractual appointments	11.76	Honorarium to contractual staff
4	GIA to Vision Centres	15.00	places the vision centre has to be established-
5	GIA to Eye Bank	30.00	subsidised eye care services for underserved affected population in Rural / Tribal/ Underserved areas
<b>TOTAL</b>		<b>1296.76</b>	

**APPROVAL OF NIDDCP**

(Rs. in lakh)

S. No.	ACTIVITY	APPROVED AMOUNT	"MAJOR" EXPECTED OUTPUT AS PER PIP
1	Establishment of IDD Control Cell	6.00	Better implementation and monitoring of programme activities.
2	Establishment of IDD Monitoring Lab	3.50	Monitoring of iodine content of salt and urine samples in districts.
3	Health Education and Publicity	12.00	Increased awareness about IDD and iodated salt.
4	IDD surveys	2.50	Prevalence of IDD in 5 districts of state
<b>TOTAL</b>		<b>24.00</b>	

APPROVAL OF NLEP

(Rs. in lakh)

S. No.	ACTIVITY	APPROVED AMOUNT	"MAJOR" EXPECTED OUTPUT AS PER PIP
1	Contractual Services	13.50	Functional leprosy cell at state/district level
2	Services through ASHA/USHA	9.00	Increase in %of cases reported by ASHA
3	Office expenses & Consumables	10.00	Functional leprosy cell at state/district level
4	Capacity building	20.00	Improvement in skills in diagnosis & treatment
5	Behavioural Change Communication	25.00	Better self reporting by increased awareness
6	POL/Vehicle operation & hiring	22.00	Improvement in mobility of SLOs & DLOs
7	DPMR	22.50	Decrease in recurrence of foot ulcers and
8	Material & Supplies	12.00	Management of reaction cases
9	Urban Leprosy Control	19.50	Better diagnosis & treatment in urban areas
10	NGO - SET Scheme	4.50	Increase in NGO support
11	Supervision & Monitoring	2.00	Better, supervision & monitoring of programme
12	Cash assistance	10.00	Better, supervision & monitoring of programme
<b>TOTAL</b>		<b>170.00</b>	

APPROVAL OF NPPCD

(Rs. in lakh)

S. No.	ACTIVITY	APPROVED AMOUNT	"MAJOR" EXPECTED OUTPUT AS PER PIP
1.	Training of Manpower	48.00	Trained manpower
2	Capacity building District Hospitals	76.00	Strengthened ear care service delivery system
3	Capacity building of PHCs/CHCs	38.50	
4	Manpower at district level	32.40	Strengthened ear care service delivery system
5	Screening Camps	21.60	Early identification of Hearing impaired
6	Hearing Aids	58.39	Medical rehabilitation of Hearing impaired children
7	Central Cell at state level	4.22	Coordinate, liaison with central and district level for better and speedy implementation of the programme
<b>Total</b>		<b>279.11</b>	

## MONITORING TARGETS TO BE ACHIEVED IN 2010-11

S. No.	Activity / Measurable indicator	Achievement in/up to 2009-10	Target (Cumulative) in/up to 2010-2011	Addition during the year
/	<b>Monitorable Progress Against Standards :</b>			
A	<b>Maternal Health</b>			
1	Institutional Deliveries	65.1 %(DLHS 3)	90%	24.9%
2	24x7 Facilities	961	1200	239
3	Functional First Referral Units	141	192	51
4	Functional Sub Centres	8875	8875	0
B	<b>Child Health</b>			
5	Sick New Born Care Units	0	47	47
6	Stabilization Units in CHCs/BPHCs	114	201	87
7	Full Immunization	76.7% (DLHS-3)	90%	13.3%
C	<b>Population Stabilization</b>			
8	Male sterilization	10477	21477	11000
9	Female Sterilization	3.89 lakhs	5.20 lakhs	1.31 lakhs
10	No. Of IUD insertions	231101 (up to Jan 10)	308250	77149

S. No.	Activity / Measurable indicator	Achievement in/up to 2009-10	Target (Cumulative) in/up to 2010-2011	Addition during the year
<b>D</b>	<b>Disease Control</b>			
11	Annualized New Smear Positive Detection Rate	61% (2009)	>70%	9%
12	Success Rate of New Smear Positive	81% (2009)	>85%	4%
13	ABER for malaria	17.7% (2009)	18%	2
14	API for malaria (per 1 thousand population)	0.7(2009)	0.7	
15	No. of Reconstructive surgeries performed under NLEP (per 1 thousand population)	93 (upto January 2010)	193	100
16	Annual New Case Detection Rate for Leprosy(per 1,00,000 population)	7.3	7.0	
17	Cataract Surgeries performed	290977 (upto feb)	400000	109023
<b>II</b>	<b>Human Resources including Training</b>			
18	Appointment of ANMs	0	1032	1032
19	Appointment of staff nurses	3117	4550	1433
20	Percent of ANMS trained as Skilled Birth Attendant	8993 (in nos)	9440 (in nos)	447
21	Doctors trained on EmOC	40	76	36
22	Doctors trained on LSAS	67	95	28
23	Doctors trained in NSV/Conventional vasectomy	25	325	300
24	Doctors trained in Abdominal Tubectomy (Minilap)	313	373	60
25	Doctors trained in laparoscopic Tubectomy	111	141	30
26	Personnel trained in IMNCI	1856 (AWW-1581 ANM-196 Doctors-65 Nurses-14)	7856 (Planned in 9 other districts)	6000
S. No.	Activity / Measurable indicator	Achievement in/up to 2009-10	Target (Cumulative) in/up to 2010-2011	Addition during the year

<b>III</b>	<b>Communitisation Processes.</b>			
27	Functional VHSCs	23026	29406	6380
28	ASHAs completed four modules of training (minimum 15 days training)	23500	39195	15695
29	ASHAs with Drug kits	23500	38500	15000
30	Percent expenditure of NRHM funds through Non Governmental organizations	8%	20%	12%
31	Percentage Districts having community monitoring system in place	14%	100%	86%
<b>IV</b>	<b>Flexible Financing</b>			
32	Percent utilization of untied grants	70%	100%	30%
<b>V</b>	<b>Improved Management:</b>			
33	Percent districts uploading timely HMIS Data and confirming	100%	100%	0
34	Tracking of pregnant mothers and children	Training in NBITS at state completed	12.45 lakhs pregnant women & 10.68 lakhs – 1 year infants	100%
35	Computerisation of HMIS (level of data entry, and unit of data entry)	PHC-2193 (Nos)	2193	0
36	Cold chain Management (number of functional ILR points)	2288	2413	125
37	Procurement System (implementation of ProMIS / TNSC like structure)	50%	100%	50%
<b>VI</b>	<b>Backward District Focus</b>			
38	Functional Mobile Medical Units	35	61	26
39	Poor performing districts sub-plan made with targets, and quarterly review shows progress	0	7	7
40	Difficult, Most Difficult, inaccessible area thrust in provision of infrastructure and human resources.	438	1569	1131

NATIONAL RURAL HEALTH MISSION

RECORD OF PROCEEDINGS 2010-11

Record of Proceedings of the National Programme Coordination Committee (NPCC) for Karnataka held under the Chairmanship of Shri P.K. Pradhan, Additional Secretary and Mission Director, NRHM for approval of NRHM Programme Implementation Plan (PIP) of State and UTs for the year 2010-11.

I. A meeting of the NPCC of NRHM was held under the Chairmanship of AS & MD, NRHM, to approve the PIP of Karnataka on 09/02/2010. The list of members who attended the meeting is placed at **Annex. VI**. The NPCC meeting was convened after the pre-appraisal meeting for the State, with written and oral comments provided to the State to modify the proposal before the NPCC.

II. State Government apprised about the likely uncommitted unspent balance available under NRHM as on 1.4.2010, and were apprised of the GOI Resource Envelope for 2010-11 under NRHM which is 15% higher than current year's Budget Estimate for over planning purpose and 15% State share. It was also clarified that the actual resource allocation shall be in accordance with the budgetary allocation of 2010-11 and may be lower than the resource envelope indicated. The Monitorable Targets for the State was also indicated. It was stated that the budgets may be realigned to achieve Monitorable Targets in case there has been inadequate provision in the PIP, to meet national goals. After detailed discussions and subsequent deliberations, the PIP was finalised for amounts indicated under different components as detailed in the Annexure I to V.

**III. The attention of the State was drawn to the following areas for further action :**

**A. Planning**

1. The State Government shall, within 45 days of the issue of Record of Proceedings by the Ministry of Health and Family Welfare, issue detailed Record of Proceedings for each district.

**B. Human Resource**

2. All posts under NRHM on contract and based on local criteria shall be done by the Rogi Kalyan Samiti /District Health Society. Residence at place of posting must be ensured.
3. Blended payments comprising of a base salary and a performance based component, should be encouraged.
4. Transparent transfer and career progression systems should be implemented in the State.
5. The State shall put in place a transparent and effective human resource policy so that difficult, most difficult and inaccessible areas attract and retain human resources for health.

**C. Infrastructure**

6. The State shall furnish list of facilities to be upgraded with identification of inaccessible and remote facilities and finalization of district action plans for the identified backward districts within three months.
7. The State shall furnish information relating to physical and financial status of infrastructure and building works already taken up every quarter to Infrastructure Division.
8. The State shall under take all construction activities in meeting health infrastructure gaps with particular focus in backward districts and inaccessible facilities.

**D. Communitisation**

9. The State shall take up capacity building exercise of Village Health and Sanitation Committees, Rogi Kalyan Samitis and other community /PRI institutions at all levels, involving Non Governmental organizations after a selection process.
10. The State shall ensure regular meetings of all community Organizations /District /State Mission with public display of financial resources received by all health facilities.
11. The State shall also make contributions to Rogi Kalyan Samitis besides introducing user charges wherever feasible protecting the interest of the poor.
12. All performance based payments/incentives should be under the supervision of Community Organizations (PRI)/RKS.

13. The State shall focus on the health entitlements of vulnerable social groups like SCs, STs, OBCs, minorities, women, disabled friendly, migrants etc.

#### **E. HMIS**

14. State shall set up a transparent and credible procurement and logistics system. State agrees to periodic procurement audit by third party to ascertain progress in this regard.

15. The State shall undertake institution specific monitoring of performance of Sub Centre, PHCs, CHCs, DHs, etc. in the prescribed format which is to be regularly uploaded as Monthly, Quarterly and Annual Data on the HMIS.

#### **F. Specific Programme Related**

16. The State shall operationalise fixed day services in family planning in addition to periodic camps.

17. The states shall henceforth provide only F-IMNCI training to doctors and staff nurses whilst IMNCI is to be provided only to ANMs/AWW and other field functionaries.

18. The State Govt. would co-locate AYUSH in PHCs/CHCs, wherever feasible.

19. (Any State Specific Conditions/Observations)

- New construction – all the health facilities which have started construction work in 2008-09 should be completed within next 6 months and the ones that started in 2009-10 should be completed by March 2011. Completed facilities should be put to use within 1 month of completion of work.
- Contractual/regular MPWs should be in position in all SHCs in Back ward districts.
- The performance targets for National Disease control programmes, namely RNTCP, NVBDCP and NLEP are revised as per GoI targets.

IV. Based on the State's PIP and deliberations thereon the Plan for the State is finalised as per the detail of Annexure I (RCH Flexible Pool), Annexure II (NRHM Flexible Pool), Annexure-III (Immunization) & Annexure -IV (National Disease Control Programmes) with summary of Infrastructure , Human Resource and Training at Annexure V.

## PART A: RCH II 2010-11

## APPROVAL OF RCH II PIP 2010-11: Karnataka

(Rs. in lakh)

S. No.	BUDGET HEAD	PROPOSED	APPROVED
1	Maternal Health	142.20	10.62
2	Child Health	427.50	427.50
3	Family Planning	416.00	416.00
4	ARSH	135.00	135.00
5	Urban RCH	480.73	480.73
6	Tribal RCH	0.00	0.00
7	Vulnerable Groups	263.00	263.00
8	Innovations/ PPP/ NGO	287.50	287.50
9	Infrastructure & HR	7311.71	6276.29
10	Institutional Strengthening	491.34	491.34
11	Training	1800.00	1743.00
12	BCC / IEC	800.00	780.00
13	Procurement	1229.56	1229.56
14	Programme Management	1240.57	840.57
	<b>Total RCH II Base Flexi Pool</b>	<b>15025.11</b>	<b>13381.11</b>
15	JSY	5074.03	4602.58
16	Sterilisation & IUD Compensation, and NSV Camps	5030.29	5030.29
	<b>Total RCH II Demand Side</b>	<b>10104.32</b>	<b>9632.87</b>
	<b>GRAND TOTAL RCH II</b>	<b>25129.43</b>	<b>23013.98</b>

**NOTE:**

1. Activities have been re-classified as per FMR/ Operating Manual heads; details are provided in attachment "A".
2. Details of activities approved/ not approved, and specific comments, are provided in attachment "A".
3. Expenses are to be booked as approved in attachment "A".
4. The above includes Rs. 1229.56 lakhs for drugs, proposed by the State under Mission flexible pool, shifted to RCH II (see details in attachment "A", under A.13 - Procurement).
5. The supplies of the RCH drugs from the Ministry of Health and family Welfare are likely to reach the States by September 2010. Therefore, the State may assess its RCH drugs requirement against the present supplies made/ being made by MOHFW through UNOPS as well as the State's own procurement, and use the approved budget for procurement of RCH drugs only if required for meeting the need for the period up to September 2010

## KARNATAKA

(Rs. Lakhs)

FMR Code	ACTIVITY	PROPOSED AMOUNT	APPROVED AMOUNT	EXPECTED OUTPUT	REMARKS
<b>A.1</b>	<b>MATERNAL HEALTH</b>				
A.1.3	<b>Integrated outreach RCH services</b>	131.58	0.00		Community Health Days -is not an activity related to RCH, hence not approved.
<b>A.1.4</b>	<b>Janani Suraksha Yojana/ JSY</b>				1. Budget has not been calculated as per the JSY norms in some places which has been corrected i.e. ASHA incentive in tribal areas. Admin expenses @ 5% of JSY amount which comes to 219 lakhs). 2. State govt may provide Rs. 200 as ASHA incentive in tribal areas till the revised JSY guidelines came into existence; budget has been modified accordingly.
A.1.4.1	Home Deliveries	244.82	244.82	For 48964 beneficiaries	
A.1.4.2	Institutional Deliveries				
A.1.4.2.1	Rural	2890.00	1750.00	For 250000 beneficiaries	
A.1.4.2.2	Urban		788.56	For 131427 beneficiaries	
A.1.4.2.3	Caesarean Deliveries	730.21	730.20	For 48680 beneficiaries	
A.1.4.3	Other activities (JSY)	1209.00	1089.00	1) ASHA incentive for JSY(3 tribal districts) - 10000 ASHAs 2) ASHA incentive for JSY(other districts) - 425000 ASHA	
<b>A.1.5</b>	<b>Other strategies/activities</b>				

<b>FMR Code</b>	<b>ACTIVITY</b>	<b>PROPOSED AMOUNT</b>	<b>APPROVED AMOUNT</b>	<b>EXPECTED OUTPUT</b>	<b>REMARKS</b>
A.1.5.1.	Maternal Death Audit	10.62	10.62	Review of 1250 maternal deaths	Transaction costs
	<b>Sub-total Maternal Health (excluding JSY)</b>	<b>142.20</b>	<b>10.62</b>		
	<b>Sub-total JSY</b>	<b>5074.03</b>	<b>4602.58</b>		
<b>A.2</b>	<b>CHILD HEALTH</b>				NSSK and IMNCI have not been planned by the State
A.2.2	Facility Based Newborn Care/ FBNC	225.00	225.00	For 3000 sick new borns	F-IMNCI for MOs/SNs includes facility based new born care.
A.2.3	Home Based Newborn Care/ HBNC	10.00	10.00	Review of ASHA performance in 7 districts	
A.2.8	Other strategies/activities	192.50	192.50	Running costs of 2 NRCs; Retinopathy project in 5 districts	(1) Rs. 50.00 lakhs for 2 NRCs. (2) Rs. 142.50 lakhs for Retinopathy project.
	<b>Sub-total Child Health</b>	<b>427.50</b>	<b>427.50</b>		
<b>A.3</b>	<b>FAMILY PLANNING</b>				
A.3.1	<b>Terminal/Limiting Methods</b>				
A.3.1.1	Dissemination of manuals on sterilisation standards & QA of sterilisation services	10.00	10.00	10000 manuals	
A.3.1.2	Female Sterilisation camps	300.00	300.00	2000 female sterilisation camps	Though State has referred these activities as 'Fixed

<b>FMR Code</b>	<b>ACTIVITY</b>	<b>PROPOSED AMOUNT</b>	<b>APPROVED AMOUNT</b>	<b>EXPECTED OUTPUT</b>	<b>REMARKS</b>
A.3.1.3	NSV camps	350.00	350.00	1000 NSV camps	Day Static Services'; this is a camp based approach. Hence budget head has been classified under 'Sterilisation Camps' head.
A.3.1.4	Compensation for female sterilisation	4468.64	4468.64	355275 female sterilisation cases	
A.3.1.5	Compensation for male sterilisation	150.00	150.00	10000 male sterilisation cases	
<b>A.3.2</b>	<b>Spacing Methods</b>				
A.3.2.2	IUD services at health facilities / compensation	61.65	61.65	308250 IUD insertions	compensation for IUD insertion
<b>A.3.4</b>	Repairs of Laparoscopes	50.00	50.00	50 laparoscopes	The State may explore undertaking Annual Maintenance Contract (AMC) for all the laparoscopes starting next year.
<b>A.3.5.</b>	Other strategies/ activities	56.00	56.00	1) 30 QA meetings 2) 1.00 lakhs beneficiaries to be covered by ASHA for follow up of IUD insertion	To be paid to ASHA for 4 follow up of beneficiary (of IUD)
	<b>Sub-total Family Planning (excluding compensation)</b>	<b>416.00</b>	<b>416.00</b>		
	<b>Sub-total Sterilisation &amp; IUD compensation &amp;</b>	<b>5030.29</b>	<b>5030.29</b>		

<b>FMR Code</b>	<b>ACTIVITY</b>	<b>PROPOSED AMOUNT</b>	<b>APPROVED AMOUNT</b>	<b>EXPECTED OUTPUT</b>	<b>REMARKS</b>
	<b>NSV camps</b>				
<b>A.4</b>	<b>ARSH</b>				
A.4.2	Other strategies/activities	135.00	135.00	Sensitisation of self-help group members, teachers, and PRIs (at PHC level); Taluk level essay and debate competitions and Yuvajana melas; Taluk level jathas in 4 districts; Taluk and district level workshops in 2 districts; training of 30 programme officers	
	<b>Sub-total ARSH</b>	<b>135.00</b>	<b>135.00</b>		
<b>A.5</b>	<b>URBAN RCH</b>				
A.5.2	Other strategies/activities	480.73	480.73	For 44 urban health centres	
	<b>Sub-total Urban RCH</b>	<b>480.73</b>	<b>480.73</b>		
<b>A.6</b>	<b>TRIBAL RCH</b>				
	<b>Sub-total Tribal RCH</b>	<b>0.00</b>	<b>0.00</b>		
<b>A.7</b>	<b>VULNERABLE GROUPS</b>				
A.7.1.	Services for Vulnerable groups	263.00	263.00	In 7 districts	

<b>FMR Code</b>	<b>ACTIVITY</b>	<b>PROPOSED AMOUNT</b>	<b>APPROVED AMOUNT</b>	<b>EXPECTED OUTPUT</b>	<b>REMARKS</b>
	<b>Sub-total Vulnerable Groups</b>	<b>263.00</b>	<b>263.00</b>		
<b>A.8</b>	<b>INNOVATIONS/ PPP/ NGO</b>				
A.8.1	PNDT and Sex Ratio	187.50	187.50	State level workshop, quarterly Taluk level workshops.	Detailed breakup of costs and physical targets for the activities to be provided by the State.
A.8.3	NGO Programme	100.00	100.00	For 14 NGOs	
	<b>Sub-total Innovations/PPP/NGO</b>	<b>287.50</b>	<b>287.50</b>		
<b>A.9</b>	<b>INFRASTRUCTURE &amp; HR</b>				
<b>A.9.1</b>	<b>Contractual Staff &amp; Services</b>				
A.9.1.1	ANMs	329.84	329.84	447 ANMs + 20 ANMs in tribal area	
A.9.1.2	Laboratory Technicians	76.44	76.44	98 LTs	
A.9.1.3	Staff Nurses	3822.00	3822.00	4550 SNs	
A.9.1.4	Doctors and Specialists (Anaesthetists, Paediatricians, Ob/Gyn, Surgeons, Physicians)	450.00	450.00	75 Doctors	
A.9.1.5	Other contractual staff	947.65	947.65	1) 200 MOs; 2) 105 contractual staff for CH (NICU) 3) 7 other consultants	
A.9.1.6	Incentive/ Awards etc.	1685.78	650.36	Remote area	Following are not

FMR Code	ACTIVITY	PROPOSED AMOUNT	APPROVED AMOUNT	EXPECTED OUTPUT	REMARKS
				allowance; Incentive to ASHA for 179167 non-JSY beneficiaries (ANC registration, 3 ANC, 100 IFA tablets, 2 TT, 6 PNC visits, accompanying the pregnant women for institutional delivery and staying with them)	approved: • 9.1.7 ASHA Incentive for MH services - Rs. 1075.00 lakhs (ANC registration: Rs. 50; 3 ANC + IFA 100 tablets + 2 TT: Rs. 50; 6 times PNC: Rs. 50; Accompanying ANC's and staying throughout with them, for institutional deliveries: Rs. 450) for non JSY beneficiaries; State may note that, JSY guidelines can not be changed hence only Rs. 89.58 lakhs (@ Rs. 50 per beneficiary for 179167 beneficiaries) for incentive to ASHA for PNC is approved  9.1.8 ASHA Incentive for CH services - Rs. 50.00 lakhs; incentives for home visits of newborns not supported.
	<b>Sub-total Infrastructure &amp; HR</b>	<b>7311.71</b>	<b>6276.29</b>		
<b>A.10</b>	<b>INSTITUTIONAL STRENGTHENING</b>				
A.10.2	Logistics management/ improvement	43.34	43.34	Computer consumables, LAN, computer	

<b>FMR Code</b>	<b>ACTIVITY</b>	<b>PROPOSED AMOUNT</b>	<b>APPROVED AMOUNT</b>	<b>EXPECTED OUTPUT</b>	<b>REMARKS</b>
				training	
A.10.3	Monitoring & Evaluation / HMIS	340.00	340.00	1) Printing of 20000 registers 2) Printing of 8.60 lakhs HMIS forms 3) Training of 196 staff in HMIS	
A.10.5	Other strategies/ activities	108.00	108.00	Quality assurance to be implemented in 18 districts	
	<b>Sub-total Institutional Strengthening</b>	<b>491.34</b>	<b>491.34</b>		
<b>A.11</b>	<b>TRAINING</b>				
A.11.1	<b>Strengthening of Training Institutions</b>	99.00	99.00	for 25 training centres	
<b>A.11.3</b>	<b>Maternal Health Training</b>				
A.11.3.1	Skilled Birth Attendance / SBA	300.00	300.00	500 MOs in 100 batches, 500 SN in 190 batches and 900 ANM's in 300 batches will be trained	
A.11.3.2	EmOC Training	50.00	50.00	48 MO's in 6 batches	
A.11.3.3	Life saving Anaesthesia skills training	28.70	28.70	28 MO's in 7 batches	
A.11.3.4	MTP training	7.68	7.68	32 in 16 batches	
A.11.3.5	RTI / STI Training	22.44	22.44	1650 (	

<b>FMR Code</b>	<b>ACTIVITY</b>	<b>PROPOSED AMOUNT</b>	<b>APPROVED AMOUNT</b>	<b>EXPECTED OUTPUT</b>	<b>REMARKS</b>
				MO+LT+SN)	
A.11.4	<b>IMEP Training</b>	33.60	33.60	1700 (MO+SN)	
A.11.5	<b>Child Health Training</b>				
A.11.5.1	IMNCI	340.00	340.00	6450 (MO, SN, ANM/ LHV, AWW)	for MOs/SNs F-IMNCI is considered for remaining IMNCI training is required.
A.11.5.3	Home Based Newborn Care	405.15	405.15	6962 (ASHA TOT's and ASHA)	
A.11.5.5	Other CH Training	106.90	106.90	3840 (MO and SN from district hospitals and SN of PHC)	
A.11.6	<b>Family Planning Training</b>				
A.11.6.1	Laparoscopic Sterilisation Training	12.60	12.60	30 batches	
A.11.6.2	Minilap Training	13.80	13.80	60 batches	
A.11.6.3	NSV Training	18.00	18.00	300 MO's	
A.11.6.4	IUD Insertion Training	160.50	160.50	5400 (MOs, SNs, LHVs, ANMs)	
A.11.7	<b>ARSH Training</b>	119.63	119.63	4500 (MOs, SNs, ANMs)	
<b>A.11.8</b>	<b>Programme Management Training</b>				
A.11.8.1	SPMU Training	57.00	0.00		Training of AYUSH MOs is not approved under RCH flexi pool;

<b>FMR Code</b>	<b>ACTIVITY</b>	<b>PROPOSED AMOUNT</b>	<b>APPROVED AMOUNT</b>	<b>EXPECTED OUTPUT</b>	<b>REMARKS</b>	
A.11.8.2	DPMU Training	25.00	25.00	266 persons to be trained		
	<b>Sub-total Training</b>	<b>1800.00</b>	<b>1743.00</b>			
<b>A.12</b>	<b>BCC/IEC</b>					
A.12.1	<b>Strengthening of BCC/IEC Bureaus</b>	13.92	13.92	Lump Sum budget provided		
A.12.2	<b>Development of State BCC/IEC strategy</b>	75.00	75.00			
A.12.3	<b>Implementation of BCC/IEC strategy</b>	32.00	32.00			
A.12.3.1	BCC/IEC activities for MH	252.00	252.00			
A.12.3.2	BCC/IEC activities for CH	200.00	200.00			
A.12.3.3	BCC/IEC activities for FP	197.00	197.00			
A.12.3.4	BCC/IEC activities for ARSH	10.08	10.08			
A.12.4	<b>Other activities</b>	20.00	0.00			Rs. 20.00 lakhs for Anti-tobacco campaign not approved under RCH flexi pool
	<b>Sub-total BCC/IEC</b>	<b>800.00</b>	<b>780.00</b>			
<b>A.13</b>	<b>PROCUREMENT</b>					
A.13.2	<b>Procurement of Drugs and supplies</b>					
A.13.2.1	Drugs & supplies for MH	118.00	118.00		The following are shifted to Mission flexi pool: Rs. 55.00 lakhs for RTI/ STI kit; and Rs. 63.00 lakhs	

<b>FMR Code</b>	<b>ACTIVITY</b>	<b>PROPOSED AMOUNT</b>	<b>APPROVED AMOUNT</b>	<b>EXPECTED OUTPUT</b>	<b>REMARKS</b>
					for Misoprostol.
A.13.2.5	General drugs & supplies	1111.56	1111.56		The following are shifted to Mission flexi pool: Rs. 361.25 lakhs for Kit A & Kit B; Rs. 300.31 lakhs for PHC kits; Rs. 150.00 lakhs for CHC kits; and Rs. 300.00 lakhs for FRU kits.
	<b>Sub-total Procurement</b>	<b>1229.56</b>	<b>1229.56</b>		<b>Please see additional comments in Annex 2, below summary of RCH II approvals.</b>
<b>A.14</b>	<b>PROGRAM MANAGEMENT</b>				
A.14.1	<b>Strengthening of State society/ SPMU</b>	400.00	400.00		
A.14.2	<b>Strengthening of District society/ DPMU</b>	200.00	200.00		
A.14.3	<b>Strengthening of Financial Management systems</b>	24.57	24.57		
A.14.4	Other activities (Program mgmt. expenses, mobility support)	616.00	216.00		Rs. 400.000 lakhs for untied fund is not approved.
	<b>Sub-total Program Management</b>	<b>1240.57</b>	<b>840.57</b>		
	<b>Total RCH II Base Flexi Pool</b>	<b>15025.11</b>	<b>13381.11</b>		
	<b>Total RCH II Demand Side</b>	<b>10104.32</b>	<b>9632.87</b>		

<b>FMR Code</b>	<b>ACTIVITY</b>	<b>PROPOSED AMOUNT</b>	<b>APPROVED AMOUNT</b>	<b>EXPECTED OUTPUT</b>	<b>REMARKS</b>
	<b>GRAND TOTAL RCH II</b>	<b>25129.43</b>	<b>23013.98</b>		

## **ECLASSIFICATION OF ACTIVITIES**

Activities from the revised PIP sent by the state (post NPCC) have been reclassified as per the FMR/ operating manual heads. State needs to comply with this while booking the expenses and reporting in FMR:

1. Activity 1.3.3. Community Health Days has been merged with "A.1.3. Integrated outreach RCH services"
2. Activity 1.4.3. Other activities (JSY) includes:
  - 1.4.3. Monitor quality and utilisation of services JSY administrative expenses & others).
  - 1.4.3.1. ASHA Incentive for JSY (3 Tribal Districts)
  - 1.4.3.2. ASHA Incentive for JSY (Other Districts)
3. Activity A.3.5. Other strategies/activities includes:
  - 3.5. State Level Workshop (QA committee meeting in districts)
  - 3.5.2. ASHA Incentive for IUD follow up
4. Activity A2.8 Other strategies/activities includes:
  - 2.8. Other strategies/activities (ROP/ Audit/Monitoring)
  - Nutritional rehabilitation centres
5. Activity A.9.1.1 ANMs salary includes:
  - 9.1.1. ANMs recruited and in position
  - 6.1.3. Implementation of Tribal RCH activities (Rs. 8.00 lakhs for tribal ANM's salary)
6. Activity A.9.1.5. Others - Computer Assistants/ BCC Co-ordinator/ ASHA Link Worker etc includes:
  - MOs
  - Other contractual staff for CH (NICU)
  - State consultants salary

7. Activity A.9.1.6. Incentive/ Awards etc. to ASHA Link worker/ SN/ MOs etc includes:
  - 6.1.3. Implementation of Tribal RCH activities (Rs. 48.00 lakhs)
  - 9.1.6 Incentives and awards (remote area allowance)
  - 9.1.7 ASHA Incentive for MH services
  - 9.1.8 ASHA Incentive for CH services
  
8. Activity A.10.3 Monitoring & Evaluation / HMIS include:
  - 10.3.2.1. Review of existing registers
  - 10.3.2.2. Printing of new forms
  - 10.3.2.3. Training of staff
  - 10.3.3. Other M&E activities - Evaluation work/ mobility for monitoring/procurement of *Thayi* card, computer printers/scanners /AMC
  
9. 8.4.2. Quality Assurance has been shifted to “A.10.5. Other strategies/ activities”
  
10. 11.5.2. Facility Based Newborn Care / FBNC has been merged with “Activity A.11.5.5 Other CH Training”.
  
11. 11.9. Other training (AYUSH/MOs-SPMU) has been merged with “Activity A.11.1 SPMU Training”

## SUMMARY OF MISSION FLEXIBLE POOL (MFP) PIP 2010-11

(Rs. in lakh)

Sl.No	Activity	Proposed Amount	Approved Amount	Expected outputs	Remarks
<b>B</b>	<b>TIME LINE ACTIVITIES - Additionalities under NRHM (Mission Flexible Pool)</b>				
<b>B1</b>	<b>ASHA</b>				
B1.1	Selection of ASHA	5.5	5.5	1000 ASHA @ Rs. 0.0055 lakh selected	Approved
B1.2	Procurement of ASHA Drug Kit	90	90	15000 ASHA @ Rs. 0.0066 lacs with Drug kits	Approved
B1.3	Bags for ASHA	46.00	46.00	23000 bags @ Rs. 0.002 lacs purchased & distributed	Approved
B1.4	ASHA monitoring (M&E)	216.00	216.00	9000 ASHA completed training 200 ASHA @ Rs. 1.08 lacs	Approved
B1.5	ASHA Training	585.00	585.00	9000 ASHA @ Rs. 0.65 lacs	Approved
<b>Total for ASHA</b>		<b>942.50</b>			
<b>B2</b>	<b>Untied Funds</b>				
B2.1	Untied Fund for CHCs	162.00	162.00	Funds to 324 CHC provided to ensure CHC is providing service guarantee	Approved @50,000

B2.2	Untied Fund for PHCs	548.25	548.25	Funds to 2193 PHC provided to ensure PHC is providing service guarantee	Approved @25,000
B2.3	Untied Fund for Sub Centers	814.30	814.30	Funds to 8143 SHC provided to ensure that no. of households deprived of basic health care is able to receive service guarantee as per IPHS	Approved @ 10,000
B2.4	Untied fund for VHSC	2302.60	2940.60	Funds to 29406 VHSC provided to ensure that households deprived of basic health care is able to receive service guarantee as per IPHS	Approved for 29406VHSC @ 10,000 as per meetings in 2008-09
B2.5	Untied grants for urban health centres	22.00	22.00	Funds to 44 UHC provided to ensure UHC is providing service guarantee	Approved 44 UHC @ Rs. 0.50 lakh
<b>Total for untied funds</b>		<b>3849.15</b>			
<b>B3</b>	<b>Hospital Strengthening</b>				
<b>B4</b>	<b>Annual Maintenance Grants</b>				
B4.1	CHCs	324.00	324.00	Funds to 324 CHC to ensure CHC is providing service guarantee and upgradation as per IPHS	Approved @ 1.00 lakh
B4.2	ANMTCs	19.00	19.00	Funds to 19 ANMTC and upgradation as	Approved @ Rs. 1.00 lakh

				per IPHS	
B4.3	PHCs	977.50	977.50	Funds to 1955 PHC to ensure PHC is providing service guarantee and upgradation as per IPHS	Approved @50,000
B4.4	Sub Centres	510.20	510.20	Funds to 5102 SHC to ensure SHC is providing service guarantee and upgradation as per IPHS	Approved @ 10,000
<b>Total for B3</b>		<b>1830.70</b>			
<b>B5</b>	<b>New Constructions/ Renovation and Setting p</b>				
B 5.1.1	Spill over works of upgradation of FRUs to IPHS	222.81	222.81	Funds to 9 FRU and c as per IPHS	Approved Synergise the amount with ongoing construction and upgradation budgeted
B 5.1.2	Spill over works at CHCs	317.67	317.67	Funds to 4 ANMTC (CHC) for upgradation	
B 5.1.3	Spill over works at PHCs	3418.27	3000.00	Funds to 94 PHC for upgradation	
B 5.1.4	Spill over works at Sub centres	361.25	361.25	Funds to 85 SHC for upgradation	
<b>B5.2</b>	<b>New Constructions/</b>				
B5.2.1	PHCs	1250.00	1250.00	Funds to 100 new PHC for construction as per IPHS	Approved subject to detailed plan of action for rest NRHM period approved by compete
B5.2.2	SC	1315.00	1315.00	Funds to 300 new SHC and construction as per IPHS	

B5.2.3	Upgradation of MCH facilities & others	115.00	115.00	Funds to 5 MCH for upgradation as per IPHS	nt authority.
<b>Total for B5</b>		<b>7000.00</b>			
<b>B6</b>	<b>Corpus Grants to HMS/RKS</b>				
B6.1	District Hospitals	85.00	85.00	Funds to 17 DH provided for ensuring the service guarantee	Approved @ 5.00 Lakh
B6.2	CHCs	178.00	178.00	Funds to 178 CHC provided for ensuring the service guarantee	Approved @ 1.00 Lakh
B6.2.1	Taluka hospitals	292.00	146.00	Funds to 146 Taluka provided for ensuring the service guarantee	Approved @ 1.00 Lakh
B6.3	PHCs	2193.00	2193.00	Funds to 2193 PHC provided for ensuring that service guarantee	Approved @ 1.00 Lakh
<b>Total for B6</b>		<b>2748.00</b>			
<b>B7</b>	District Health Action Plans (Including Block, Village)	35.00	35.00	Formation of 29 DAPS	
<b>Total for B7</b>		<b>35.00</b>			
<b>B 8</b>	<b>Panchayati initiative</b>				
B.8.1	Capacity building to VHSC /ARS	1350.00	1350.00		Approved
<b>Total for B8</b>		<b>1350</b>			
<b>B9</b>	<b>Mainstreaming of AYUSH</b>				

B 9.1	AYUSH Activities	3188.03	1300.00	Salary for 640 Doctors 2 Doctors Yoga and Naturopathy, 2 PG Doctors, 300 paramedical Staff, IEC, Training of 200 Doctors	Approved. Salary of Doctors, paramedical staff, IEC and Training
<b>Total for B9</b>		<b>3188.03</b>			
<b>B 11</b>	<b>Mobile Medical Units</b>				
B11.1	Mobile Medical Units	450.00	450.00	100% utilisation of recurring cost for 30 MMU .	Approved 30 MMU @ Rs. 15 lacs
<b>Total for B11</b>		<b>450.00</b>			

<b>B 12</b>	<b>Referral Transport</b>				
B12.1	Capital Cost of Ambulances providing EMRI		5102.00	Capital cost for 367 EMRI 92 ALS @Rs.18.40 lakhs 275 BLS @ Rs.12.40 lakhs	Approved
B12.2	Arogya Kavacha (EMRI)	4500.00	4500.00	recurring cost for 517 EMRI	Approved @ 40%, considering it as 2nd year.
<b>Total for B 12</b>		<b>4500.00</b>			
B13	School Health Programme (Suvarna Arogya Chaitanya)	1100.00	1100.00	Medical Examination, Training/Meeting/W orkshops/IEC. Health promotion activities, transportation and M&E (Annexure 1)	Approved
<b>Total for B 13</b>		<b>1100.00</b>			

<b>B14</b>	<b>Additional Contractual Staff (Selection, Training, Remuneration)</b>				
<b>B14.1</b>	<b>Additional Staff/ CHC</b>				
B14.1.1	Janani Suraksha Vahini-Driver/recurrin cost for mobile phone	334.35	330.24	100% utilisation of recurring cost for 384 driver. 384 driver@ Rs. 0.86 lacs comes to Rs. 330.24 lacs	Approved
B14.2	Additional ANM, for Sub-Centre (in 6 C districts)	540.00	540.00	751 ANM recruited in 6C districts. 750 ANM @ Rs. 0.72 lacs	Approved. It should be synergised with the facilities
<b>Total for B 14</b>		<b>874.35</b>			
<b>B16</b>	<b>Training</b>				
B16.3.3	Other training and capacity building programmes (Diploma in Public Health )	25.00	25.00	training of personnel	Approved
<b>Total for B 16</b>		<b>25.00</b>			
<b>B17</b>	<b>Incentives Schemes</b>				
B17.1	Incentives to EMOC training and LSAS trained MBBS doctors working in FRUs	50.00	50.00	training of personnel	Approved.
17.2	<b>Other innovative schemes</b>				
B17.2.1	Madilu Kit	5600.00	2800.00	Kits to BPL/SC/ST women procured and distributed	Approved
B17.2.2	Social unrest & Naxal affected area service action plan	100.00	100.00	PHC and CHC functional as per IPHS to ensure service guarantee 20 PHC+CHC @ Rs.	Approved.

				5.00 lacs	
B17.2.3	Outsourcing of MCH services in FRUs	10.00	10.00	FRUs outsourced	Approved
B17.2.4	Integration of ICTCs	249.00	249.00	facilities integrated 83 ICTCs located in PHCs	Approved.
B17.2.5	Nutritional Support to the Mother	500.00	0.00		Not Approved
B17.3	Blood line Rakta Vahini	57.60	57.60	Rakta Vahini 8 Districts, 1200 units @ Rs. 600 per unit	Approved
<b>Total for B17</b>		<b>6566.60</b>			
<b>B18</b>	<b>Planning, Implementation and Monitoring</b>				
B18.1	Community Monitoring (Visioning workshops at state, Dist, Block level)	5.0	5.0	Implementation of community monitoring activities in (workshops at state, Dist, Block level) 30 districts in place	Approved
B18.3	Monitoring and Evaluation				
B18.3.1	Computerization HMIS and e-governance, e-health	50.00	50.00		Approved
<b>Total for B18</b>		<b>55.00</b>			
<b>B19</b>	<b>Procurements</b>				
<b>B19.1</b>	<b>Equipments</b>				

B.19.1.1	Procurement of equipment: MH	831.40	831.40	MH Equipments procured to provide service guarantee	Approved subject to submission of detailed plan of action
B.19.1.2	Procurement of equipment: CH	961.07	961.07	47 SNCUs and 201 Stabilisation units.	Approved
B.19.1.3	Procurement of equipment: FP	216.75	216.75	FP equipments	Approved
<b>B 19.1.4</b>	<b>Others</b>				
B.19.1.4.1	Equipments to newly constructed 94 PHCs	188.00	188.00	95 new PHC equipped to provide service guarantee as per IPHS	Approved 94 PHCs @ Rs. 2.00 lacs
B.19.1.4.2	Furniture to newly constructed 94 PHCs	65.80	65.80	95 PHC furnished to provide service guarantee as per IPHS	Approved 94 PHCs @ Rs. 0.70 lacs
B.19.1.4.3	Equipment to newly constructed sub centers (138 Sub centers)	27.60	27.60	139 SHC equipped to provide service guarantee as per IPHS	Approved subject to detailed 138 SCs @ Rs. Rs. 0.20 lacs
B.19.1.4.4	Furniture to Newly constructed sub centers (138 Sub centers)	19.32	19.32	139 SHC equipped to provide service guarantee as per IPHS	Approved 138SCs @ Rs. 0.14 lacs
B.19.1.4.9	Generators & UPS for new PHCs & 24x7 PHCs	100.00	100.00	100% uninterrupted electricity supply to ensure service guarantee	Approved
<b>Total for procurement of equipments</b>		<b>1991.67</b>			
<b>B.19.2</b>	<b>Procurement of Drugs and supplies . General drugs &amp; supplies for health facilities</b>				

	( For SC, PHC&CHC/FRU as per MoHFW)				
B.19.2.1	Drugs & supplies for SCs (including Kit A & Kit B)	361.25	0.00		Shifted to RCH Flexi pool
B.19.2.2	For PHCs	300.31	0.00		
B.19.2.3	For CHCs	150	0.00		
B.19.2.4	For FRUs	300	0.00		
B.19.2.6	Anaemia treatment of pregnant women with parenteral iron	24.00	24.00		Approved
B.19.2.7	Misoprostol	63.00	0.00		Shifted to RCH Flexi pool
B.19.2.8	Vitamin A Procurement	100.00	100.00		Approved
B.19.2.9	Drugs & supplies for RTI/STI	55.00	0.00		Shifted to RCH Flexi pool
<b>Total for procurement of Drugs</b>		<b>1353.56</b>			
<b>Total for B19</b>		<b>3345.23</b>			
B23	<b>Health Insurance Scheme</b>				
B23.1	Yeshaswini benefit for HIV +ve deliveries	60.00	60.00	1000 @ Rs. 0.06 lacs beneficiaries insured.	Approved
<b>Total for B23</b>		<b>60.00</b>			
<b>B24</b>	<b>Research, Studies, Analysis</b>				
B24.1	Anemia Pilot Study	269.64	269.64	Analysis done, report submission and dissemination	Approved
<b>Total for B24</b>		<b>269.64</b>			
<b>B25</b>	<b>State level health resources center(SHSRC)</b>				

B25.1	State level health resources center (SHSRC)	50.00	50.00	Merging of health resource center in 1974 under World Bank Project and NRHM Personnel recruited and SHSRC functional	Approved
<b>Total for B25</b>		<b>50.00</b>			
<b>B27</b>	<b>NRHM Management Costs/ Contingencies</b>				
B27.1	Block Level BPMU	528.00	528.00	Block programme managers 176 @ 1.20 lacs, block level accounts assistants 176 @ Rs. 0.90 lacs, Block level data entry operators 176 @ Rs. 0.90 lacs	Approved
B27.2	Audit Fees	10.00	10.00		Approved
B27.4	Concurrent Audit system	36.00	36.00	30 @Rs. 1.20 lacs	Approved
B27.8.1	Training of District Accounts Managers	5.0	5.0	Details not provided in PIP	Approved
B27.8.2	Management cost	316.8	316.8		Approved
<b>Total for Programme Management</b>		<b>895.8</b>			
<b>B.29</b>	<b>Other Expenditures</b>				
B	Grant for 9 new ANM Training Centres	105.53	105.53	9 new ANM Training Centres operational ANM enrolled and certified	Approved
B 29.1	Rent for Sub centre	200.00	200.00	100% utilisation of rent by SHC	Approved
B 29.3	Providing one Refrigerator Mechanic to each district and one to	44.64	44.64	Refrigerator Mechanic in place at each district and state HQ	Approved

	state HQ by outsourcing				
B 29.5	<b>RNTCP</b>				
	STDC(IRL) Civil Works, Electric Backup generator, Fabrication for walk in cold room and walk in incubator rooms	36.00	36.00	1) Culture & DST Lab at Bangalore fully functional as planned;	Approved as per Comments from Programme Division
	Travelling expenses of DOTs Plus Patients and investigations in DOTs Plus Patients	10.4	10.4	for investigations and travelling expenses of DOTs-Plus patients	
	5 Lab attendants' at IRL	3.6	3.6	Contractual Lab attendants posted at IRL	
B 29.5	Total for RNTCP	50.00		Rs.36 lakhs for civil works, Rs. 10 lakhs for 50 microscopes, 5 LTs at STDC	
B 29.6	Citizens Help Desk	168.00	168.00	Operational Citizens Help Desk at 20 DH @ Rs. 8.40 lacs	Approved
	Human resource	36.96	0.00		Not approved
	Vehicle Hiring/Transport	27.00	27.00		Approved as per Comments from Programme Division
	Special control Plan for malaria in Mangalore & Udupi towns	37.24	0		To be met from state resources as these are justified but being the urban area state should meet the cost
B 29.7	Total for NVBDCP	101.20			

B 29.18	Miscellaneous (State)	50.00	50.00		Approved
B 28.19	Mobility support for M&E	508.00	508.00		Approved
B 28.20	Best performance awards	50.00	50.00		Approved
				For the period of April 2010 to November 2010	
B 28.21	Stipend for trainee ANMs	129.92	129.92	a1) Rs.1200 x 600 x 9 x 8 m <u>June 2010 Batch</u> (From June 2010 to March 2011) a2) Rs.1200 x 600 x 9 x 10 m	Approved
B 28.22	Hiring of vehicles	19.00	19.00	19 Vehicles hired for recurring cost	Approved
	<b>Total under NRHM</b>	<b>1426.29</b>	<b>39627.5</b>		
	<b>Deafness</b>		<b>4.22</b>		
	<b>RCH</b>				
1	Integrated outreach RCH services	131.58	0.00		Not approved. To be integrated with health melas and VHNDs
2	SPMU Training	57.00	0.00		Not Approved, as Training of AYUSH MOs is already approved in AYUSH mainstreaming
3	Other activities	20.00	20.00	Rs. 20.00 lakhs for Anti-tobacco campaign may be budgeted from Mission Flexi Pool/ other sources; not approved under RCH flexi pool	Approved as ongoing activity
	<b>Sub Total RCH</b>	<b>208.58</b>	<b>20.00</b>		
	<b>GRAND TOTAL</b>	<b>41751.00</b>	<b>39651.72</b>		

**Immunization Strengthening Programme Karnataka (2010-11)**

(Rs. in lakh)

S. No.	Activities	Amount Proposed	Amount Approved	Remarks
1.	Mobility support for Supervision and Monitoring at districts and state level.	14.50	14.50	
2	Cold chain maintenance	30.80	25.94	
3.	Alternate Vaccine Delivery to Session sites	132.24	132.24	
4.	Focus on urban slum & underserved areas	63.46	63.46	
5	Social Mobilization by ASHA /Link workers	281.47	281.47	
6	Computer Assistants support at State& district level	34.80	34.80	
7	Printing and dissemination of immunization cards, tally sheets, charts, registers, receipt book, monitoring formats etc.	80.00	49.00	
8	Quarterly review meeting at state level	5.00	5.00	
9	Quarterly review meeting at block level	14.50	14.50	
10	Three days training of Mos on RI	29.00	14.50	
11	One day cold chain handlers trainings	10.00	8.70	
12	POL for vaccine delivery from state to District and PHC/CHCs	7.80	7.80	
13	ASHA incentive for AEFI reporting	1.00	0.00	
14	Purchase of Generator for Dist Vaccine Store at state level	50.00	0.00	
Total		<b>754.57</b>	<b>651.91</b>	

**Comments**

As per the evaluated survey the **full immunization** is **76.8%** as per DLHS-3(2007-08). The sustained high coverage of BCG at around 90% and Measles over 85 % is impressive.

The identification of the districts with low coverage as per the DLHS-3 reports like Raichur, Bijapur, Bagalkot, Belgaum, Bellary and Gulbarga which have high BCG-DPT-3 dropout rate is

a step in right direction. It is however important to identify the reasons for the dropout in these districts.

The initiative to identify the dropouts and display list in the VHSC office is a good strategy to track the dropouts. However, the state needs to take steps to improve beneficiary tracking and generate community demand to reduce the dropout rate for further improvement in coverage.

**The State needs to:**

Status of activities conducted during last year need to be elaborated.

Some of the low performing districts are tribal districts. The IEC to generate community demand need to be designed to address the local issues and should not be only generic for the entire state.

State has proposed annual district level surveys for health; while this is a good strategy to assess the health situation, efforts should be made to strengthen regular reporting system through encouraging factual reporting to appraise the ongoing status of activities.

State has not projected funds for Micro-planning, Injection safety.

Items restricted or not permissible under Immunization PIP

ASHA incentive for AEFI reporting-Rs.1.00 lakh -Not admissible under Immunization PIP.

Purchase of Generator for Dist Vaccine Store at State level- Rs50.00 lakh -Not admissible under Immunization PIP.

**ANNEX-IV**

**APPROVAL UNDER THE NATIONAL DISEASE CONTROL PROGRAMMES**

**RNTCP**

(Rs. in lakh)

S. No.	Activity Proposed	Amount Approved	Expected Output	Remarks
1	Civil works	23.00	1) Civil work Upgradation and maintenance completed as planned	
2	Laboratory materials	96.00	1) Sputum of TB Suspects Examined per lac population per quarter;	

			2) All districts subjected to IRL OSE and Panel Testing in the year; 3) IRLs accredited and functioning optimally;	
3	Honorarium	25.00	1) All eligible Community DOT Providers are paid honorarium in all districts in the FY;	Utilised only 12.5 lakh in the last 4 qtrs
4	IEC/ Publicity	30.00	1) All IEC/ACSM activities proposed in PIP completed; 2) Increase in case detection and improved case holding	Utilised only 13 lakh in the last 4 qtrs
5	Equipment maintenance	19.00	1) Maintenance of Office Equipments at State/Districts and IRL equipments completed as planned; 2) All BMs are in functional condition;	
6	Training	80.00	1) Induction training, Update and Re-training of all cadre of staff completed as planned;	eligible amount is 48.5 lakhs
7	Vehicle maintenance	59.00	1) All 4 wheelers and 2 wheelers in the state are in running condition and maintained;	
8	Vehicle hiring	30.00	1) Increase in supervisory visit of DTOs and MOTCs; 2) Increase in case detection and improved case holding	Amount spent in last 4 qtrs is only 20 lakhs
9	NGO/PP support	60.00	1) Increase in number of NGOs/PPs involved in signed schemes of RNTCP; 2) Contribution of NGOs/PPS in case detection and provision of DOT	Amount spent in last 4 qtrs is only 7 lakhs, more amount can be allotted if more schemes gets signed and amount payed in first two quarters.

10	Miscellaneous	95.00	1) All activities proposed under miscellaneous head in PIP completed;	
11	Contractual services	800.00	1) All contractual staff appointed and paid regularly as planned;	
12	Printing	50.00	1) All printing activities at state and district level completed as planned;	Amount spent in the last 4 qtrs is only 16 lakhs
13	Research and studies	14.00	1) Proposed Research has been initiated or completed in the FY as planned;	
14	Medical Colleges	100.00	1) All activities proposed under Medical Colleges head in PIP completed; 2) Funds in the head utilized against approved amount	No details regarding number of posts of contractual staff etc are not available.
15	Procurement - vehicles	0.0	1) Procurement of vehicles completed as planned;	No sanction for procurement of vehicle from CTD obtained
16	Procurement - equipment	10.00	1) Procurement of equipments completed as planned;	No sanction for laptops, SDS equipments mentioned etc
17	Total	1491.00		

In addition to this, a commodity grant of Rs. 414.7 lacs has been approved for central level procurement of Anti TB Drugs and Laboratory Equipments for sputum culture & drug sensitivity.

## PERFORMANCE

(i) Targets to be achieved during 2010-11:

- Detection rate of at least 70% and maintain treatment success rate above 85%.
- All RNTCP districts have supervisory structure for disease control programme.

(ii) Information under 27-B:

State	Annualized NSP case detection rate	Success rate of NSP
Karnataka	61%	81%

**The State need to strengthen the services in the following districts:**

District	ANSPCDR	Success Rate
Bagalkot	55.5%	76.7%
Bangalore City	60.4%	79.6%
Bidar	46.2%	83.2%
Bijapur	41.3%	68.9%
Chamarajanagar	64.9%	84.7%
Dakshina Kannada	51.9%	78.6%
Davanagere	52.3%	81.6%
Dharwad	48.7%	82.3%
Gadag	59.9%	82.6%
Gulbarga	49.6%	70.9%
Haveri	67.4%	76.4%

Kodagu	42.7%	82.9%
Ramanagara	59.5%	75.5%
Shimoga	57.7%	84.6%
Tumkur	68.2%	82.3%
Udupi	45.9%	82.8%
Uttara Kannada	46.9%	80.0%

#### HUMAN RESOURCE:

Vacancy position of various categories of staff and the training status of existing staff is placed below:

DTO			MOTC			STS			STLS			DMC LT/Microscopist		
Sanctioned	Vacancy	Total in place & trained	Sanctioned	Vacancy	Total in place & trained	Sanctioned	Vacancy	Total in place & trained	Sanctioned	Vacancy	Total in place & trained	Sanctioned	Vacancy	Total in place & trained
30	0	27	124	3	84	125	2	112	125	4	116	632	8	577

Medical Officer (at BPHC/PHC/CHC /district hospital /other)		Paramedical staff including health workers	
Vacancy	In place and yet to be trained	Vacancy	In place and yet to be trained
705	922	4304	3729

New Contractual Position:

The following new contractual positions have been sanctioned under the revised financial norm of RNTCP for building capacity of districts and states to implement new initiatives like TB HIV Collaborative services and programmatic management of MDR TB:

State Level Positions:

- Asst. Programme Officer/Epidemiologist - 1 per state
- DOTS Plus Site Sr. Medical Officer - 1 per DOTS Plus site
- DOTS Plus Site Statistical Assistant - 1 per DOTS Plus site
- Sr. LT at IRL - 1 per IRL
- Store Assistant (SDS) - 1 per SDS
- DEO (IRL) - 1 per IRL

District Level Positions:

- Sr. DOTS Plus and TB HIV Supervisor - 1 per district (as per phased expansion of DOTS Plus and intensified TB-HIV activities)

State is requested to fill up all existing vacancies as well as new contractual positions and arrange for the training of the staff.

**NVBDCP**

		(Rs.in lakh)			
S.No.	Activity Proposed	Amount Proposed	Amount Approved	Expected Output	Remarks
1	<b>DBS (Domestic Budgetary Support)</b>				
1.1	<b>Malaria (DBS)</b>				

	MPWs contractual engagement		54.00	improved surveillance	state has requested for 100 MPWs on contractual basis which should be planned and activities should be initiated (salary for 09 months only approved as 3 months will be for the process of recruitment)
	Training of MPWs, PHC Mos,LTs	35.70	3.00	improved capacity of MPWs, ASHAs and Mos	The fund earmarked for ASHA should be utilized for training of medical and para medical staff along with the fund earmarked for training
	ASHA	0.00	25.00		
	Monitoring & Evaluation including MIS-NAMMIS	29.60	18.75	Timely reporting	
	IEC/BCC/PPP	0.00	35.00	social mobilization and awareness generation	state has not asked for malaria but asked for Rs.28.80 lakh for filaria at state level and has not asked for IEC at district level. This fund may be used for ELF, social mobilization at state and district level.
1.1.1	<b>World Bank Phase II components</b>				
	Human resource	95.08	0.00		Not approved at this stage. This will be considered during 2011-12.
	Training	89.25			
	Mobility support	13.95			
	Human resource for ROH&FW	2.25	0.00		

	Mobility Support for ROH&FW	0.10			
1.2	<b>Filaria</b>				
	Elimination of Lymphatic Filariasis - preparatory activities including coordination committee meetings, training, mopping up operations, transport, night blood survey and M&E	30.95	80.00	Timely completion and observance of MDA with improved drug compliance for reducing microfilaria rate	Preparatory activities are essential and needs to be completed before the observance of Mass Drug Administration and the funds required are justified. However, if the releases are made in first and second quarter to the districts and periphery and the activities are performed as per calendar of activities with submission of SOE, the additional funds will be considered at the RE state. The total proposed amount is approved for ROP. IEC activities at state and district level including grass root IEC may be met out of the funds mentioned in IEC Malaria.
	Honorarium to drug distributor and supervisors for drug distribution during MDA	61.40		Timely drug distribution with improved compliance by community	
	IEC/BCC including social mobilization	28.80		Timely sensitization of health and non health sector of officials on MDA and improving drug compliance for reducing microfilaria rate	
1.3	<b>Dengue &amp; Chikungunya</b>				

	Grant in aid for SSH	3.50	7.00	early diagnosis & treatment to reduce case fatality rate	For 14 (including additional) sentinel surveillance hospitals @ Rs.0.50 lakh as per GoI norms
	Grant for apex lab	1.00	1.00		
	Epidemic preparedness	37.80	15.00		Activities may be met within the available resources and for balance, it should be integrated with malaria and other VBDs.
	Training	11.10	5.00	improved capacity of medical and para medicals	Should be integrated with the training of other programmes to meet the additional requirement
	Emergency intervention	4.90	0.00		already provided in epidemic preparedness
	M&E, Rapid response	19.50	17.00	quick reporting	
	IEC	0.00	7.00	awareness generation	State has not planned awareness activity which is essential for prevention of vector breeding in and around houses and the IEC activities should focus on such activities
1.4	<b>AES/JE</b>				
	Training	3.92	3.00	improved capacity of medical and para medicals	

	Diagnostic management & AES	10.00	8.00	early diagnosis & treatment to reduce case fatality rate	
	IEC	5.00	3.00	awareness generation	
	M&E strengthening	4.00	2.00	quick reporting	
	Technical Malathion	5.00	1.00	fogging to affected area in outbreaks	
<b>2</b>	<b>Kala-azar</b>	<b>0.00</b>	<b>0.00</b>	<b>Not endemic</b>	
<b>3</b>	<b>Decentralised drugs &amp; larvicides (DBS)</b>	<b>164.18</b>	<b>89.46</b>	No shortage of drugs	
	<b>Total cash assistance including cost of decentralized commodities</b>	<b>656.98</b>	<b>374.21</b>		
4	Commodity support by GoI for VBD	0	163.2		
	<b>Grand Total cash + commodity</b>	<b>656.98</b>	<b>537.41</b>		

### Karnataka (Physical Targets)

Activity	State Average (5 Years)	Target for 2010-2011	Remarks
ABER	17.96% 2008--17% 2009--17.75%	18.00%	Filling up of the MPWs (4381 out of 8143) posts will be needed for improving surveillance

API cases per thousand population	2008-0.89 2009-0.7	0.7 per thousand population	
Percent Coverage of Targetted Population under Insecticidal Residual Spray (IRS)	65.95% coverage of population (2009) 73.02% coverage of rooms (2009)	Minimum target of population coverage is 80%	For better analysis of IRS, Room coverage of more than 70% is to be achieved
Training	-	Minimum 2 batches of MOs, 1 batch of DMOs and 30% of ASHAs, LTs and MPWs to be trained for malaria and other VBD activities	Priority in training should be given to districts reporting falciparum malaria
Appointment of Human Resource	Out of 29 districts 28 DMOs are sanctioned but 25 are in position. 100 contractual MPWs need to be filled up by June end	One post of DMO need to be created and all the 4 need to be filled.	
Distribution and utilization of LLINs	Not applicable	Not applicable	-
The district wise API is >2 in AKP Almatti, UKPN PURA, Chikkaballapur, Raichur, Koppal, Dakshina Kannada and Gulbarga. Efforts should made to train all ASHAs and community volunteers to enable early diagnosis and complete treatment of these cases at village level			

## IDSP

(Rs. in lakh)

Activity	Amount	Amount	Expected Outcome	Remarks
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Proposed	proposed	Approved		
1. Surveillance preparedness, training & staff salary 2. Outbreak investigation 3. Analysis & use of data  <b>Annexure-I</b>	433	294	1. Training of professionals (DSO, Epidemiologists, Microbiologists, Entomologists 2. IT network for transmission of data and outbreak reporting 3. Strengthening of lab. 4. Surveillance and reporting of disease outbreaks 5. Strengthening of AI surveillance	would be met from EAP

**IDSP**

**(Rs. in lakhs)**

<b>Budget-sheet - Karnataka ( Districts - 29 )</b>					
<b>Activity</b>	<b>Sub-activity</b>	<b>Tasks</b>		<b>2010 - 11</b>	<b>Remarks</b>
Surveillance Preparedness	1. Training	1.1	Training of Hospital Doctors	4.46	20 per district, 10 per batch, 2 batch per district Per head training cost = Rs.1100/-. Unit cost per participant: training material Rs.100; travel: Rs.300; Food: 250 (10
		1.2	Training of Hospital Pharmacist / Nurses	6.09	40 per district, 20 per batch, 2 batch per district per head training cost = Rs.750/-. Unit cost per participant: training material Rs.50; travel: Rs.100; Food: 150 (20 x 300) + Other exp
		1.3	Training of Medical College Doctors	1.20	16 per medical college, per head training cost = Rs.2150/- Unit cost per participant: training material Rs.150; travel: Rs.1000; Food: 250 (20 x 1400) + Other expenses Rs.5000 ; Trainer charges: Rs.10000 = Total Rs.43,000/- per batc

		1.4	Training of Medical College Pharmasist/ Nurses/ Medical Record Technician	0.35	12 per college, Per head training cost = Rs.850/-. Unit cost per participant: training material Rs.50; travel: Rs.200; Food: 150 (20 x 400) + Other expenses Rs.5000 ; Trainer charges: Rs.4000 = Total Rs.17,000/- per b
		1.5	Data entry and analysis training for Block Health Team	3.04	15 per district, per head training cost = <b>Rs.1000/-</b> . Unit cost per participant: training material Rs.50; travel: Rs.300; Food: 200 (20 x 550) + Other expenses Rs.5000 ; Trainer charges: Rs.4000 = Total Rs.20,000/- p
		1.6	DM & DEO training	1.04	Per head training cost= Rs.1600 /-, 2 days training Unit cost per participant: {[training material Rs.50 + Food 150 x 2] + travel: Rs.500} x 20 + Other expenses (computer hiring) Rs.10000; Trainer charges: Rs.4000 = Total Rs.31,000/- per batch
			<b>SUB TOTAL</b>	<b>16.20</b>	
	2. Staff Salary	2.1	Epidemiologists (30)	75.60	Rs 30000 per month
		2.2	Microbiologists (3)	7.20	Rs 20000 per month
		2.3	Entomologists(1)	2.40	Rs 20000 per month
		2.4	Consultants (Finance) (1)	1.68	Rs 14000 per month

	2.4.1	Consultants (Training) (1)	3.36,	Rs 28000 per month
	2.5	Data Managers (30)	48.66	Rs 13500 per month
	2.6	Data Entry Operators (35)	3.57	Rs 8500 per month
	2.7	Mobility Support	34.80	(Rs 1000 per visit x 10 visits)/ per month per district
	2.8	Office Expenses @ Rs.2000 P.M.	7.56	Rs 2000 at districts and Rs 5000 at SSU per month
		<b>SUB TOTAL</b>	<b>216.96</b>	
3.	3.1	Community Sensitisation	1.20	Rs 1 20 000 per State
Community Surveillance	3.2	Review meetings (monthly) at PHC level	0.16	Rs 1400 per month in States where CBS is planned
	3.3	Contingency	0.24	Rs 2000 per month in States where CBS is planned
	3.4	Evaluation	0.25	Rs 25 000 per state per year
		<b>Sub TOTAL</b>	<b>1.85</b>	
		<b>Sub Total of Surv.Prepare</b>		
4	4.1	ASHA incentives for Outbreak reporting	3.48	Estimated to get 10 informations per month from volunteers a total of 120 such information in a year per district. Each informant to be given an incentive of Rs.100/-

		4.2	Medical college/Institute participation in outbreak investigation	1.45	At an average cost of Rs.5000/- per outbreak x 2 outbreaks per year. In the current year only 1 investigation in 225 districts is expected.
		4.3	Consumables and kits for lab	4.00	Rs 200 000 per lab (17 total - 2 labs in 8 states + 1 lab in Punjab)
		4.4	Collection & Transpsortation of samples	1.74	Rs 6000 per district per year
		4.5	Referral lab network	40.00	Rs 5 00 000 per referral lab per year
			<b>Sub Total of Outbreak Investigation and response</b>	<b>50.67</b>	
	5	5.1	State IDSP Weekly Alert Bulletin	0.30	Rs 30 000 per SSU per year
		5.2	Annual IDSP report	0.20	Rs 20 000 per SSU per year
		5.3	Printing of Reporting Forms	3.40	Rs 10000 per district and Medical College per year
		5.4	Broadband Expenses	4.20	Rs 1000 per district+SSU+Medical Colleges per month
		5.5	Meetings State Epidemiologists and Microbiologists	0.50	Rs 50 000 per State
			<b>Sub Total Of Analysis and use of Data</b>	<b>8.60</b>	

## NPCB

(Rs.in lakh)

S. No.	Programme/Activity	Unit of measure	UNIT COST	No. of units Proposed	Amount	Approved		
H	<b>NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS(NPCB)</b>							
H.1	<b>Cataract Surgeries</b>							
H.1.1	GIA to NGOs for Cataract Surgeries as per package approved under 11th plan	per surgery	0.0075 0	2,20,000	1650.00	<b>1200.00</b>	Approved under GIA	
H.1.2	Recurring GIA to Private Practitioners for Free Cataract surgeries (New Initiative of GOI as per Table.11 )	per surgery	0.0075 0	10,000	<b>75.00</b>		Approved under GIA	
H.1.3	Incentive to ASHA to motivate patients for Cataract operations in low performing blocks, and Districts.	per case	0.0017 5	4,710	<b>8.24</b>		Approved. Under Scheme GIA For Cataract Operation & other approved activities*.	
H2	<b>Contractual Appointments:</b>							
H.2.1	Honorarium to DPM(BCD) @ Rs.2000/- PM x 12 months	per District	0.2400 0	29	<b>6.96</b>		Approved. Under Scheme GIA For Cataract Operation & other approved activities*.	

H.2.2	Operational Cost for DH and F.W.Society(BCD) @ Rs.150,000/- per annum per District ( Remuneration for Part time AA, Drivers, Office expenses, Stationery, Postage / Courier services, meetings, TA/DA etc	per District	1.5000 0	29	<b>43.50</b>		
H.2.3	Appointment of Ophthalmic Surgeons on contract basis for 2 Districts @ Rs.25,000/- per OS per month,( <b>New initiative of GOI to ensure adequate manpower</b> )	per District	3.00	2	<b>6.00</b>	<b>6.00</b>	
H.2.4	Appointment of PMOAs on contract basis for - 6 PHCs or/ Vision Centres of Districts where PMOAs posts are vacant @ Rs.8,000/- each PMOA per month, ( <b>New initiative of GOI to ensure adequate manpower</b> )	per District	0.96	6	<b>5.76</b>	<b>5.76</b>	
H.2.5	Eye Donation Councillors for Eye Banks in Govt/ Voluntary Sector @ Rs.10000/- PM for each Councillors - ( <b>New initiative of GOI to ensure adequate manpower</b> )	per Eye Bank	1.20	2	<b>2.40</b>		

H.2.6	<b>Recurring Grant in Aid for Management of KSH and F.W. Society (Blindness Control Division):</b> To meet Remuneration of contractual Staff, TA/DA, Honorarium to SPO(NPCB), Quarterly Review Meetings, Hiring of Vehicles /POL,, Maintenance of Office equipments etc.,AMC, Contingencies, & Operational expenses.	State level				20.00	Approved under GIA
H.3	<b>IEC activities:</b>						
H.3.1	IEC activities by Dist.H and F.W.Society(BCD) @ Rs.2,00,000/- per district for WSD, E.D.Fortnight and other occasions	per District	2.00	29		58.00	Approved under GIA
H.3.2	<b>IEC activity:</b> Prinitng and supply of Hoardings, Pamphlets, Posters, Calendars, Advertisements, TV /Cable, AIR, Newspapers, Awareness on Eye Donation among the public to motivate and increase eye ball collection required for Keratoplasty, WSD, EDFN 2010	State level				30.00	
H.4	<b>Training Activities:</b>						
H.4.1	Training activities by DH and F.W.Society(BCD) @ Rs.25000/- per district ASHA / Anganwadi under NPCB	per District	0.2500 0	29		7.25	Approved under GIA

H.4.2	<b>Training activity at State Level :</b> Training of MOs CHC/PHC , Staff Nurses, PMOAs including manuals	State level				<b>6.50</b>		
H.5	POL and maintenance of Vehicles (including hiring of vehicles for camps)	per District	0.5500 0	29		<b>15.95</b>		Approved under GIA
H..6	Schemes for Blind Schools: To provide visual aids to Two Blind schools in Karnataka to provide support for rehabilitation of incurably blind.	per Blind School	1.0000 0	2		<b>2.00</b>		Approved. Under Scheme GIA For Cataract Operation & other approved activities*.
H.7	<b>Strengthening of Medical Colleges: Non recurring assistance @ Rs.40 lakhs</b> for procurement of Ophthalmic Equipment as commodity assistance for development of Paediatric Eye Unit / Low vision unit / Retina Units, Audio visual aids (As per annexure III A of GOI).	per Medical college	40.00	1		<b>40.00</b>	<b>40.00</b>	Approved
H.8	<b>Strengthening of District Hospitals: Non recurring assistance @ Rs. 20 lakhs</b> for procurement of Ophthalmic Equipment to improve eye care facility.(As per annexure III B of GOI).	pre District Hospital	20.00	2		<b>40.00</b>		Approved. Under Scheme GIA For Cataract Operation & other approved activities*.

H.9	<b>Strengthening of Taluk Hospitals: Non recurring assistance @ Rs. 5 lakhs for procurement of Ophthalmic Equipment to improve eye care facility.(As per annexure III B of GOI).</b>	per Taluk Hospital	5.00	5	<b>25.00</b>	Approved. Under Scheme GIA For Cataract Operation & other approved activities*.
H.10	<b>School Eye Screening</b>					
H.10.1	<b>a) School Eye Screening @ Rs.1,25,000/- each dist for Teachers Training and 20000 spectacles for School Children @ Rs.200/- per child.</b>	per District	1.25	29	<b>76.25</b>	Approved. Under Scheme GIA For Cataract Operation & other approved activities*.
H.11	<b>New initiative :</b>					
H.11.1	Glaucoma, Diabetic Retinopathy, Laser Technique, Corneal Transplantation Childhood Blindness, Squint Surgery, @ Rs.1000/- per case treated - 1000 cases for Karnataka based on all India Target of 2 lakh worth Drugs to be given to the patient.	per case	0.0100 0	1,000	<b>10.00</b>	Approved. Under Scheme GIA For Cataract Operation & other approved activities*.
H.11.2	Maintenance of Non-Recurring Assistance (Ophthalmic Equipments) through AMC 3 units @ Rs.5 lakhs per unit.	per unit	5.00	1	<b>5.00</b>	Approved. Under Scheme GIA For Cataract Operation & other approved activities*.
H.11.4	<b>Eye Banking activities:</b>					

H.11.5	<b>Recurring Assistance</b> for Eye Banks @ Rs.1,500/- as Incentive per pair of Eye Balls collected to boost eye ball collection.	per pair of Eye Balls	0.015	3000	<b>45.00</b>	Approved. Under Scheme GIA For Cataract Operation & other approved activities*.
H.11.6	<b>Recurring Assistance</b> for Eye Donation Centre @ Rs.1,000/- as Incentive per pair of Eye Balls collected to boost eye ball collection.	per pair of Eye Balls	0.010	500	<b>5.00</b>	Approved. Under Scheme GIA For Cataract Operation & other approved activities*.
H.11.7	<b>Eye Bank</b> - Development of Eye Banks in Govt. / NGO Sector to get adequate tissue for Corneal Transplantation to facilitate treatment of Corneal Blindness @ Rs.15 lakhs per Eye Bank.	per Eye Bank	15.00	2	<b>30.00</b>	Approved.
H.11.8	<b>Eye donation centre</b> - Development of Eye donation centre affiliated to registered eye banks under HOTA in Govt. / NGO Sector to get adequate tissue for Corneal Transplantation to facilitate treatment of Corneal Blindness	per EDC	1.00	5	<b>5.00</b>	

H.11.9	<b>Extension of Eyecare unit:</b> - in NGO sector in the underserved Area/Tribal Areas to provide free and subsidised eye care services for underserved affected population in Rural / Tribal/ Underserved areas @ Rs.30 lakhs per Unit to expand, upgrade and to develop capacity for sustainable eye care delivery in Voluntary Sector	per Eye care unit	30.00	1	<b>30.00</b>	<b>30.00</b>	Approved
H.11.10	<b>Vision Centre</b> - Non Recurring assistance of Rs.50000/- for basic Ophthalmic equipments for Strengthening of Vision centres at PHC level in Govt./ NGO Sector (As per annexure - III E of GOI)	per Vision Centre	0.50	60	<b>30.00</b>	15.00	Approved
H.11.11	Salary component of Joint Director (Ophth) + personal staff + Staff nurse, PMOAS, Group D and Driver working in District Units						
H.11.12	Computers with Accessories- for 30 Districts & State Programme Officer for maintenance of updation of reports	for State + 30 Districts	1.00	31.00	<b>31.00</b>		Approved. Under Scheme GIA For Cataract Operation & other approved activities*.

H.12	Procurement of IOLs for performing Cataract Surgeries	per piece	0.001	50,000	<b>50.00</b>		Approved. Under Scheme GIA For Cataract Operation & other approved activities*.
H.12.1	Operating Microscope	per piece	2.50	5.00	<b>12.50</b>		Approved. Under Scheme GIA For Cataract Operation & other approved activities*.
H.12.2	Cataract Surgery set for SICS	per piece	0.10	100	<b>10.00</b>		Approved. Under Scheme GIA For Cataract Operation & other approved activities*.
H.12.3	Disposable blades for Small Incision Cataract Surgeries	per piece	0.001	10,000	10.00		Approved. Under Scheme GIA For Cataract Operation & other approved activities*.
<b>TOTAL</b>					<b>2392.31</b>	<b>1296.76</b>	

(\*)

- All the expenditures from the NPCB budget allocations and from the funds obtained from

NRHM flexi-pool should be done strictly according to the Physical norms and Financial Norms approved in the 11<sup>th</sup> Plan five year plan of NPCB as communicated earlier.

- The above said allocations are as per the requirements proposed by the state and in case the funds in a specific allocation are exhausted the funds from other unspent allocations for NPCB activities can be utilized ; with due intimation to GOI.
- Grant-in-aid for cataract operations and various other schemes includes free cataract operation, other eye diseases, School Eye Screening Programme, training, IEC, Private Practitioners, management of State Health Society and District Health Society, recurring GIA to Eye Donation Centres and Eye Banks, maintenance of Ophthalmic Equipments, SBCS, Remuneration, other activities & Contingency etc.
- How many of the targets projected in the PIP 2009-10 have been achieved.

## NIDDCP

(Rs. in lakh)

	<b>Activity Proposed</b>	<b>Approved Amount</b>	<b>Expected Output</b>	<b>Remarks</b>
1	Establishment of IDD Control Cell	6.00	Better implementation and monitoring of programme activities.	Filling up of all sanctioned vacant posts by the state government on regular or contractual basis.
2	Establishment of IDD Monitoring Lab	3.50	Monitoring of iodine content of salt and urine samples in districts.	
3	a)Health Education and Publicity  b)Salt Testing Kits supplies by GOI (2,43,000 No)	12.00	Increased awareness about IDD and iodated salt.  Creating iodated salt demand and monitoring of the same at community level.	

4	IDD surveys	2.50	Prevalence of IDD in 5 districts of state	Survey should be conducted as per GOI guidelines of NIDDCP @ Rs. 50,000/- per district
	Total	24.00		

### NLEP

(Rs. in lakh)

S. No.	Activity proposed	Proposed Amount	Approved Amount	Expected Output	Remarks
1)	<b>Contractual Services</b>	11.46	13.50	Functional leprosy cell at state/district level	Budget includes training of ASHAs also
	State - SMO, BFO cum AO, DEO, Administrative Assistant, Driver				
	District - Drivers				
2)	<b>Services through ASHA/USHA</b>	2.65	9.00	Increase in leprosy case detection	
	Honararium to ASHA, sensitization of ASHA				
3)	<b>Office expenses &amp; Consumables</b>	10.60	10.00	Functional leprosy cell at state/district level	
4)	<b>Capacity building</b>	20.13	20.00	Improvement in skills in diagnosis & treatment of	
	4 days training of newly appointed MO (rural & urban)				

	3 days training of newly appointed health worker & health supervisor			leprosy	
	2 days refresher training of MO				
	5 days training of newly appointed Lab. Technician				
5)	<b>Behavioral Change Communication</b>				
	Quiz,folk show,IPC workshop,Meeting of opinion leaders,Health melas	30.00	25.00	Better self reporting as a result of increased awareness	
	Wall painting,Rallies,Hoardings etc				
6)	<b>POL/Vehicle operation &amp; hiring</b>				
	2 vehicles at state level & 1 vehicle at district level	23.40	22.00	Improvement in mobility of SLOs & DLOs	
7)	<b>DPMR</b>				
	MCR footwear, Aids and appliances, Welfare allowance to BPL patients for RCS, Support to govt. institutions for RCS	22.53	22.50	Decrease in recurrence of foot ulcers and reduction in grade II disability through RCS	

8)	<b>Material &amp; Supplies</b>				
	Supportive drugs, lab. reagents & equipments and printing forms	12.08	12.00	Management of reaction cases	

9)	<b>Urban Leprosy Control</b>			Better diagnosis & treatment of leprosy in urban areas	
		20.65	19.50		
10)	<b>NGO - SET Scheme</b>			Increase in NGO support	
		4.50	4.50		
11)	<b>Supervision, Monitoring &amp; Review</b>			Better, supervision & monitoring of programme	
	Review meetings and travel expenses	2.00	2.00		
12)	<b>Cash assistance</b>			Better, supervision & monitoring of programme	
		20.00	10.00		
	<b>TOTAL</b>	<b>180.00</b>	<b>170.00</b>		

The approved amount for Karnataka State under National Leprosy Eradication Programme for 2010-11 is 1.70 crores. Targets to be achieved during 2010-11 are as follows -

1. Annual New Case Detection Rate - 7.00 per 1,00,000 population
2. Reconstructive Surgery for disability correction in leprosy affected persons - 70
3. Completion of all sanctioned training activities.

## Deafness Programme

### National Programme for Prevention & Control of Deafness

The **Karnataka** State PIP has been examined by the programme division of Directorate General of Health Services

Following observations are made:

SNo.	State/UT	Existing districts	Proposed districts under NPPCD (2010-11)*
1	<b>Karnataka</b>	1. Mandya, 2. Hubli 3. Hussan 4. Kolar 5. Udipi 6. Gadag 7. Chitradurga 8. Chamaranagar 9. Bijapur 10. Tumkur 11. Chickmagalur 12. Haveri	1. Kodagu, 2. Uttara Kannada, 3. Ramanagara, 4. Chikkaballapur, 5. Bangalore rural 6. Bagalkot
		12 districts	6 districts

The state has requested for Rs 261.99 lakh for the implementation of the programme in six new proposed and 12 old districts under NPPCD. The component wise details for the projected budget is as under;

(Rs. in lakh)

S. No.	Component	Amount Proposed	Amount Approved	Expected outcome	Remark
1.	Training of Manpower	24.00	48.00	Trained manpower	
2	Capacity building District Hospitals	57.00	76.00	Strengthened ear care service delivery	@ Rs 9.5 lakh per district hospital of the selected/propo

				system	sed district)
3	Capacity building of PHCs/CHCs	66.70	38.50		@ Rs. 10,000/- for 385 new CHC/PHC of the six new selected/proposed district  Funds for CHC/PHC of old dist approved in the year 2009-10 and 50% funds were released in the same year
4	Manpower at district level	32.40	32.40	Strengthened ear care service delivery system	(Audiometric assistant & Instructor for hearing Impaired) @ Rs. 7500/- per person for 2 contractual person
5	Screening Camps	18.00	21.60	Early identification of Hearing impaired	@ Rs. 10,000/- per camp per month per district
6	Hearing Aids	58.39	58.39	Medical rehabilitation of Hearing impaired children	Approved for 12 old dist. only
7	Central Cell at state level	5.50	4.22	Coordinate, liaison with central and district level	Recommended from Mission Flexible pool Consultant @

				for better and speedy implementation of the programme	Rs 25000/-PM DEO @ Rs 6000/- PM and Office expenses of Rs 50000/- per year
	Total	261.99	279.11		

The state of Karnataka has proposed the budget of Rs 261.99 lakh for the year 2010-11 but Rs 279.11 lakh (Rs 274.89 lakh may be given from the programme budget and Rs 4.22 lakh from NRHM Flexipool budget) may be considered for approval.

**ANNEX-V**

**SUMMARY OF MAIN APPROVED ACTIVITIES (RCH & MISSION FLEXIPOOL)**

**INFRASTRUCTURE, HUMAN RESOURCE & TRAINING**

(Rs. in lakh)

S.No.	Activity	Amount Approved	Expected Output	Sanction of Fund
<b>INFRASTRUCTURE</b>				
1	Spill over works of upgradation of FRUs to IPHS	222.81	Funds to 9 FRU provided	MFP
2	Spill over works at CHCs	317.67	Funds to 4 ANMTC (CHC) provided	MFP
3	Spill over works at PHCs	3418.27	Funds to 94 PHC provided	MFP
4	Spill over works at Sub centres	361.25	Funds to 85 SHC provided 100% utilisation and upgradation as per IPHS	MFP

5	New Constructions: PHCs	1250.00	Funds to 100 new PHC provided	MFP
6	New Constructions: SC	1315.00	Funds to 300 new SHC provided 100% utilisation and construction as per IPHS	MFP
7	Upgradation of MCH facilities & others	115.00	Funds to 5 MCH provided 100% utilisation and upgradation as per IPHS	MFP
8	Capital Cost of Ambulances providing EMRI	5102.00	100% utilisation of Capital cost for 367 EMRI	MFP
9	Furniture to Newly constructed sub centers (138 Sub centers)	19.32	139 SHC equipped to provide service guarantee as per IPHS	MFP
10	Grant for 9 new ANM Training Centres	105.53	9 new ANM Training Centres operational	MFP
11	STDC(IRL) Civil Works, Electric Backup generator, Fabrication for walk in cold room and walk in incubator rooms	36 .00	1) Culture & DST Lab atBangalore fully functional as planned; 2) Funds in the head utilized against approved amount	MFP
<b>SUB-TOTAL (INFRASTRUCTURE)</b>		<b>12226.85</b>		
<b>HUMAN RESOURCES</b>				
1	Ayush Activities	1300.00	500 old and 140 new Doctor's salary	MFP
2	Additional ANM, for Sub-Centre (in 6 C districts)	540.00	751 ANM recruited in 6C districts. 750 ANM @ Rs. 0.72 lacs	MFP
3	Providing one Refrigerator Mechanic to each district and one to state HQ by outsourcing	44.64	Refrigerator Mechanic in place at each district and state HQ	MFP

4	5 Lab attendents at IRL	3.60	Contractual Lab attendants posted at IRL	MFP
5	Increased stipend for trainee ANMs	129.92	For the period of April 2010 to November 2010	MFP
6	ARSH Other strategies/activities	135.00	Sensitisation of self-help group members, teachers, and PRIs (at PHC level); Taluk level essay and debate competitions and Yuvajana melas; Taluk level jathas in 4 districts; Taluk and district level workshops in 2 districts; training of 30 programme officers	RCH
7	ANMs	329.84	447 ANMs + 20 ANMs in tribal area	RCH
8	Laboratory Technicians	76.44	98 LTs	RCH
9	Staff Nurses	3822.00	4550 SNs	RCH
10	Doctors and Specialists (Anaesthetists, Paediatricians, Ob/Gyn, Surgeons, Physicians)	450.00	75 Doctors	RCH
11	Other contractual staff	947.65	1) 200 MOs;	RCH
			2) 105 contractual staff for CH (NICU)	RCH
			3) 7 other consultants	RCH
12	Incentive/ Awards etc.	650.36	Remote area allowance;	RCH

			Incentive to ASHA for 179167 non-JSY beneficiaries (ANC registration, 3 ANC, 100 IFA tablets, 2 TT, 6 PNC visits, accompanying the pregnant women for institutional delivery and staying with them)	
13	Strengthening of State society/ SPMU	400.00		RCH
14	Strengthening of District society/ DPMU	200.00		RCH
<b>SUB-TOTAL (HUMAN RESOURCE)</b>		<b>9029.45</b>		
<b>TRAINING</b>				
1	Other training and capacity building programmes (Diploma in Public Health )	25.00	training held	MFP
2	Incentives to EMOC training and LSAS trained MBBS doctors working in FRUs	50.00	training held	MFP
3	Training of District Accounts Managers	5.00	Details not provided in PIP	MFP
4	Dissemination of manuals on sterilisation standards & QA of sterilisation services	10.00	10000 manuals	RCH
5	PNDT and Sex Ratio	187.50	State level workshop, quarterly Taluk level workshops.	RCH
6	Strengthening of Training Institutions	99.00	for 25 training centres	RCH

8	Skilled Birth Attendance / SBA	300.00	500 MOs in 100 batches, 500 SN in 190 batches and 900 ANM's in 300 batches	RCH
9	EmOC Training	50.00	48 MO's in 6 batches	RCH
10	Life saving Anaesthesia skills training	28.70	28 MO's in 7 batches	RCH
11	MTP training	7.68	32 in 16 batches	RCH
12	RTI / STI Training	22.44	1650 ( MO+LT+SN)	RCH
13	IMEP Training	33.60	1700 (MO+SN)	RCH
15	IMNCI	340.00	6450 (MO, SN, ANM/ LHV, AWW)	RCH
16	Home Based Newborn Care	405.15	6962 (ASHA TOT's and ASHA)	RCH
17	Other CH Training	106.90	3840 (MO and SN from district hospitals and SN of PHC)	RCH
19	Laparoscopic Sterilisation Training	12.60	30 batches	RCH
20	Minilap Training	13.80	60 batches	RCH
21	NSV Training	18.00	300 MO's	RCH
22	IUD Insertion Training	160.5	5400 (MOs, SNs, LHV's, ANMs)	RCH
23	ARSH Training	119.63	4500 (MOs, SNs, ANMs)	RCH
26	DPMU Training	25.00	266 persons to be trained	RCH
<b>SUB-TOTAL (TRAINING)</b>		<b>2020.5</b>		
<b>GRAND TOTAL</b>		<b>23276.8</b>		

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