

SUMMARY

State Programme Implementation Plan (PIP) is prepared for the years 2014-17 consisting of RMNCH+A, NUHM, DCPs, NCDs and Infrastructure maintenance. Detailed write ups which focuses on Goals, Strategies, Activities, and budget requirement for each activity. Justifications and deliverables are also a part of the PIP.

PIP consists of the following five parts in the write ups, annexures and budget sheets:

- PART I: RMNCH + A (NRHM + RCH including immunization) Flexipool;
- PART II: NUHM Flexipool;
- PART III: Flexipool for Disease Control Programmes;
- PART IV: Flexipool for non-communicable diseases including injury and trauma;
- PART V: Infrastructure Maintenance.

State has prepared a three year perspective plan for the period 2014-17. The three year plan is broken down by year to year in terms of key indicators i.e. goals, outcomes, outputs and process. State PIP also consists of the following:

- Quarterly targets for outcomes and outputs (HMIS)
- Detailed quarterly budgets linked to physical outputs.
- Procurement requirement for items to be supplied by centre are included as a part of the PIP. (in the annexure).
- The perspective plan for 2014-2017 has the detailed quarterly targets and budget for the first year, 2014-15.
- State PIP is an aggregate of 30 districts and 15 city health action plans.
- DP supported activities (as a part of RMNCH+A in High Priority Districts) are reflected in district/ state PIPs.
- City Plans for the first year is a part of the NHM State PIP.

RESOURCE ALLOCATION

State government will contribute 25% under NHM. And as per GoI guidelines on resource allocation to the districts is based on the following criteria:

- Upto 70% of funds allocated to districts.
- High priority districts allocated 30% more funds.
- Construction / upgrading of facilities determined by delivery points.
- Infrastructure not more 25% of the resource envelope. Facilities with higher caseloads (deliveries, OPD/OPD services) given priority for further development.
- Annual untied amount doubled for CHCs and District Hospitals based on need/case loads.

PILOTS

- Universal health coverage to reduce out of pocket expenditure and ensure universal access to assured services of quality.
- convergence workshops at State and District levels for providing improved maternal, child health and child development & nutritional services in RMNCH+ A Districts
- Nurse Mentors Program: Implementing high impact interventions in the high priority districts of northern Karnataka as a part of RMNCH+A call to action strategy
- Creating Labour Rooms with Standards - Concept Note Based on GOI MNH Tool Kit Standards.
- Establishment of Centre of excellence for Pediatric Surgery in Indira Gandhi Institute of Child Health, Bangalore

STAGES IN PLAN PREPARATION:

Key stages include:

- A state level PIP preparation team was constituted with representatives from RMNCH+A technical divisions, Urban health, disease control programmes and non-communicable diseases, finance and M&E, SHSRC.
- Preparation of district/ city plans;
- A state level situation analysis meeting under the leadership of Director, Health Services was held followed by setting of targets for goals, service delivery, outputs and corresponding strategies and activities.
- Budgeting with appropriate provisions for ongoing schemes/ initiatives like JSY, JSSK, RBSK, RKSK and entitlement related provisions such as for sterilisation, ASHA incentives and such compensation for HR
- District allocations for all programmes is prepared for 1 year period
- Once the state NHM PIP has been drafted, a state level workshop was conducted. With feedback incorporated, and appropriate modifications made into the PIP,
- This modified PIP was placed before State Health and Family Welfare Society and sent to GoI (NPCC) for approval.

RMNCH+A District Gap Analysis – Human Resource Inputs for DHAP

Background

Human Resource Planning is a mandatory part of every organization's annual planning process. Every department that plans for its health goals for the year also plans for how it will go about achieving them, and therein the planning for the human resource. To provide range of health services, each facility needs competent staff with the necessary qualifications, skills, knowledge, work experience and aptitude for work. Since HR is dynamic as employees exit both naturally and unnaturally, there is need for hiring replacement staff to augment services. Otherwise, work would be impacted. The scope of reproductive and child health services in public sector has increased manifold since NRHM. Now all the interventions are brought under 1 umbrella of RMNCH+A (Reproductive Maternal Newborn and Child Health plus Adolescent Health) In order to meet the need for more HR due to program growth and expansion, this in turn calls for larger work force.

Current situation:

St. John's Medical College, Bangalore in partnership with UNICEF, undertook the RMNCH+A Gap analysis in 8 High Priority Districts of Karnataka. The Objective of the Gap Analysis was to rapidly identify the gaps / bottlenecks in the implementation of strategic RMNCH+A interventions across life stages, in high priority districts of Karnataka. A sample of health facilities across all levels as well as community and households, was surveyed in the district.

Areas of HR Constraints:

Staff Nurses in labor room:

At PHC level – All the 24*7 PHCs in the 8 HPDs of Karnataka are conducting on an average of more than 10 deliveries per month. There are 24*7 PHCs conducting an average of more than 30 deliveries per month with only 3 staff nurses is a concern though there is a provision in the PIP.

At FRU level – The taluka hospitals in Karnataka have an average of 16-20 staff nurse for 100 bedded hospitals. The rotation of the staff is inevitable for the Medical Superintendent to manage with the existing staff. Not all the staff nurses are SBA trained. In this situation due to rotation it happens most of the time that non SBA trained SN is posted in labor room. Secondly the SN posted in labor room is not exclusively working there but assigned with multitasking of taking care of antenatal, post natal ward, injection room, etc. thus compromising effective care at delivery. Similar condition prevails in district hospital.

Staff Nurses in NBSU – Currently only 2 SNs are provided to NBSUs who are utilized for other departments in the FRUs thus leaving NBSUs non functional.

Staff Nurses in SNCU – Not all the SNCUs are provided 12 SNs and above that SNCUs with more than 20 beds need more SNs

Pediatrician and MOs at SNCU: The District Hospitals as a whole has 1 position of Pediatrician sanctioned. It is a Herculean task for 1 Pediatrician to cater daily pediatric OPD, pediatric admissions, pediatric ICU, nutritional rehabilitation centre along with SNCU admissions. There are no Medical Officers to support the Pediatrician. Newborns admitted at SNCUs require at least 4 clinical rounds by a specialist which is extremely difficult by 1 Pediatrician without duty MOs with so many other responsibilities thus, leading to low admission rate at the SNCUs. This issue is universal with more impact in HPDs.

Other HR constrains:

- There is 1 data entry operator per taluk and responsible for data entry of taluka hospital, all PHCs and subcentre in the taluka. The district gap analysis and further block monitoring visits in HPDs have shown huge mismatch in HMIS and MCTS data along with enormous duplication of data. There is no handholding and validation of the data done due to the shortage of data entry operators.
- The number of ASHAs in a taluka is less as compared to its rural population.
- Huge shortage of RCH Specialists (Pediatrician, Obstetrician, Anesthetist)

Recommendations of DHAP: (HPDs on priority)

Human resource Gaps to be addressed

Staff Nurses

4 Staff Nurses for Labor room, 4 Staff Nurses for NBSUs & Pediatrician in THs which are delivery point

8 Staff Nurses for Labor room in DHs of HPDs

15 Staff Nurses for 3 SNCUs in HPDs, (Raichur, Bijapur, Gulbarga) 12 SNs in 4 SNCUs, 6 SNs for Yadgir. 1 Pediatrician specific for SNCU in addition to 3 MOs

Data entry operators in 24*7 PHCs (Delivery Point) of HPDs – MCTS/HMIS

Bridge the gap of number of ASHAs to be adequate as per population/villages (1 per 1000 population or if small and hard to reach hamlet then 1 per 500 population)

Increase Specialists Salary Package (Rs. 1 lakh) in High Priority Talukas in High Priority Districts

PROCESS OF PLAN PREPARATION

NHM plan preparation for the years 2014-17 started in Nov. 2013 as per GoI guidelines.

1. The starting point was constitution of the state, district and city planning teams. This was done in a meeting held under the chairmanship of Mission Director (NHM). The state would be headed by Mission Director (NHM), PD (RCH) and SPM in charge of preparing State PIP. It was also decided to prepare state PIP based on DHAPs. The task of preparing district plans was given to SHSRC. SPM would coordinate with SHSRC in orienting and training state and district teams. Some of the main decisions taken were as follows:
 - To form district team under the leadership of District Programme Management officer and team consisting of all district programme officers, DPMs, and one faculty from community medicine department of the medical college in the district. In the district with no medical college will be covered by the nearest medical college.
 - One MPH/PGDPM person available in the district was to supervise the whole process of DHAP preparation. Nodal officer will also be jointly responsible for the same.
 - Data pertaining to major indicators like ANC, deliveries, immunization and other diseases, HR and infrastructure were to be obtained from village level. For these formats were to be made for various levels like Household data sheets, village data sheets, sub center data sheets, PHC data sheets, taluka data sheets and district level data sheets.
 - Specific personnel assigned the responsibility for data collection at different levels
 - ASHAs were entrusted with the responsibility of collecting household data and aggregate these into village plans.
 - ANMs for sub center plans, Medical officer for PHC plans, Taluka Health Officers and BPMs for taluka plans and DPMO along with all district level programme officer along with DPMs for district plans.
 - Completed district plans to be approved by District Health and Family Welfare Society before submitting the same to the state.
2. Preparation of DHAPs started with an orientation cum training programme for district level officers, district nodal officers, state level programme officers, representatives from medical colleges under the chairmanship of Principal Secretary, Health & Family Welfare Department. It was attended by all senior officers of the department. Mission Director (NHM) deliberated the programme, SPM and ED SHSRC briefed the gathering on the modalities in PIP preparation and explained in detail on filling up of the formats. Group activities on how to plan in a given situation were part of the training. Thus by the end of the day the participants could gain the knowledge on the intricacies of planning process.
3. Further the state teams trained the district teams which was replicated below district levels also. The guidelines to districts together with a copy of key

documents were sent to each district. Subsequently, a one-day workshop was held in every district in order to:

- Explain the key features of the guidelines.
 - Explain the criteria and process for approval of district plans.
 - Clarify any doubts/ concerns.
 - Agree timeframe.
4. Further dissemination of guidelines in plan preparation was done up to village level. ASHAs, ANMs, AWWs (where ASHAs are not functioning) were trained by PHC medical officers; Taluka teams were trained by district teams, and supervised by state level nodal person nominated for the purpose.
 5. The preparation of DHAPs took 4 months. SHSRC which was entrusted the responsibility of preparation of DHAPs completed the task by handing over copies of all 30 district plans to Mission Director (NHM).
 6. Throughout the planning process UNICEF, the development partner in the state assisted the state in preparing state and district plans.
 7. Budget allocation for each district for the years 2014-17 was given. Planning teams were given funds for planning purposes.

CURRENT SITUATION AND SITUATION ANALYSIS

3.1. Background

Karnataka State is situated in Southern peninsular India and surrounded to west by Arabian Sea, to the North by the State of Goa and part of Maharashtra, to the east by the States of Andhra Pradesh and partly by Tamil Nadu and to the south by the State of Kerala and partly by Tamil Nadu.

The total area of the state is 191791 Sq. Km. and represents 6.2% of the total area of the country. There are 30 Districts in the State of Karnataka, of which 8 are high focused Districts namely Gadag, Gulbarga, Yadgir, Koppal, Bijapur, Bagalkot, Bellary and Raichur. The Districts are further divided into 176 Talukas (blocks), containing 5628 Panchayats. There are 27397 inhabited Villages and 1943 Uninhabited Villages.

Demographics:

As per 2011 census total population of the State is 61.10 Million, out of which 38.67% reside in urban areas and 61.32% reside in rural area. The State has a population density of 319 per Sq. Km. as against the National average of 382. Among Districts, Bangalore urban with 4378 persons per Sq. Km. is the most densely populated and Kodagu is the least densely populated District in the State with a density of 135 persons per Sq. Km. The decadal growth rate of the State is 15.67% as against the National average of 17.64%, and the population of the State is growing at a slower rate than the National rate. Children between 0-6 years contributed to 11.72% of the total population.

The sex ratio is 973 Females per 1000 Males, and sex ratio of 0-6 years is 948 Females per 1000 Males (urban 946 and rural 950). The literacy rate of Karnataka is 75.4% (Male 82.8% and Female 68.1%, urban 85.8% and rural 68.7%) and India is 73.0% (Male 82.14 and Female 65.46%, Urban 84.1% and Rural 67.8%)

STATE PROFILE Annex 4.1a

DEMOGRAPHIC & SOCIO ECONOMIC INDICATORS <i>(source: CENSUS 2011/ Report - Selected Socio-Economic Statistics India-2011, Ministry of Statistics and Programme Implementation(www.mospi.gov.in))</i>					
	India	State		India	State
Total Population	1,21,05,69,573	61095297	Population Below Poverty Line (number and %age)	2697.83 lakhs (21.92%)	129.76 lakhs (20.91%)
Rural population (number and %age)	833436448 (68.8%)	37469335 (61.32%)	%age working population	481743311 (39.79%)	27,872,597 (45.62%)
Urban population (number and %age)	377106125 (31.2%)	23625962 (38.67%)	Per Capita income¹ (at current prices)	46117	52191
SC population (number and %age)	201378086 (16.63%)	10,474,992 (17.14%)	Literacy rate	Male	434683779 (80.9%)
				Female	328814738 (64.6%)
ST population (number and %age)	104281034 (8.61%)	4,248,987 (17.14%)	Gross Enrolment as percentage to the Total Population (MALES) (6-14 yrs)	104.9	100.2
%age population under 15 yrs of age	363610812 (35.34%)	1602487 (26.2%)	Gross Enrolment as percentage to the Total Population (FEMALES) (6-14 yrs)	103.7	98.3
%age population over 60 yrs of age	18.3%	5790132 (9.47%)	Drop Out Rate at Upper Primary level (MALES)	15.92%	2.33
% age population under 5 yrs of age	10.7%	7161033 (11.72%)	Drop Out Rate Upper Primary level (FEMALES)	15.27%	2.81
Sex Ratio	943	973	Drop Out Rate at Secondary level (MALES)	21.51%	5.16
Female population (number and %age)	587447730 (48.52%)	30128640 (49.31%)	Drop Out Rate Secondary level (FEMALES)	20.06%	5.66
Under 5 sex ratio	919	948			

Administrative divisions

The Karnataka State is divided into 4 Divisions namely – Gulbarga Division, Belguam Division, Mysore division and Bangalore Division.

Annex 4.1b

ADMINISTRATIVE DETAILS		
Number of Districts	30	
Number of Blocks	176	
Number of Villages – census 2011	29340	No. of Inhabited Villages-27397
Number of Cities (>50,000 population) – census 2011	65	
Name and Number of High Priority Districts– census 2011	NAME	POPULATION
HPD 1	Bagalkot	1,889,752
HPD 2	Bijapur	2,177,331
HPD 3	Bellary	2,452,595
HPD 4	Gadag	1,064,570
HPD 5	Gulbarga	2,566,326
HPD 6	Koppal	1,389,920
HPD 7	Raichur	1,928,812
HPD 8	Yadgir	1,174,271

HEALTH INFRASTRUCTURE AND SERVICE AVAILABILITY:

Annex 4.1c

FACILITY DISTANCE(source: JansankhyaSthirtaKosh: www.jsk.gov.in)		
	Number	How many of out of these villages fall in HPD
No. of villages with a PHC within 10 kms/30 mins of walking distance	12065	449
No. of villages with a 24X7 PHC within 10 kms/30 mins of walking distance	7382	2534
No. of villages with SC within 10 kms/30 mins of walking distance	19690	3065
No. of villages with CHC within 50 kms/30-60 mins of walking distance	7238	2572

Annex 4.1d

PUBLIC INFRASTRUCTURE				
	IDEAL NUMBER of FACILITIES²	EXISTING NUMBER of FACILITIES	FUNCTIONAL NUMBER of FACILITIES (complete HR, equipment, drugs and procedures/services as per IPHS norms)	FUNCTIONAL NUMBER of FACILITIES inHPDs³
SCs	State population/5000 State population/3000 As applicable	4953 3918	NA	1286 290
PHCs	State population/20000 State population/10000 As applicable	713 601	NA	58 16
24X7 PHCs	State population/20000 State population/10000 As applicable	808 223	NA	268 32
CHC	State population/80000 State population/160000 As applicable	0 206	NA	0 57
FRU	State population/500000	174	NA	34
District Hospital	No. of districts in State	20+13 District level hospitals	NA	7
MMUs	-	146		33
108/102 ambulances	-	517 +198		127+100
PRIVATE INFRASTRUCTURE				
	Number		Number existing in HPD	
Allopathic Clinics	8775		1592	
AYUSH Clinics	7777		1620	
Nursing homes	2322		2047	
Hospitals providing C-Sections	1054		2078	
Hospitals providing Cancer treatment	36		9	
Hospitals providing Cardiac treatment	205		26	
Clinics run by NGOs	31		6	
Healthcare services/facilities run by NGOs (Please mention TYPE of service viz. HIV, Leprosy, Maternity, Immunization, Cancer etc.)	38		6	

² To be calculated by State as per applicable norms

³ Out of functional facilities number of functional facilities falling in the HPDs

Developmental Partner programmes in State

Karnataka has been supported technically by the UNICEF for activities mainly focusing on child health, Nutrition, PPTCT and IEC activity, through consultants. With the roll out of RMNCH+A strategy more focus is paid on all the components of RMNCH+A in the high priority districts. A team of consultants are placed to technically support as UNICEF was selected as the lead partner for RMNCH+A activities. There are 8 high priority districts in Karnataka for the lead partners to focus on. For every two districts one district level consultants are placed.

The details of the technical support are as follows

Sl. No.	Designation	Areas Supported	Place of Operation	Support since
1	State RMNCH+A consultant	Overall in charge of the RMNCH+A activities	State Headquarters, Bangalore	Dec 2013
2	State Child health consultant	Supporting the child health division of Directorate in activities like, Infant death review and Facility based newborn care	State Headquarters, Bangalore	Jan 2010
3	State Nutrition consultant	Supporting the Nutrition division of Directorate in the child nutrition activity	State Headquarters, Bangalore	May 2012
4	State IEC consultant	Supporting the IEC division of Directorate	State Headquarters, Bangalore	Jan 2012
5	State PPTCT consultant	Supporting the Karnataka State AIDS prevention Society in the PPTCT activity	State Headquarters, Bangalore	Jan 2010
6	RMNCH+ consultant	Supporting RMNCH+A Activities of Gulbarga and Yadgir	Gulbarga ,High Focused district	Dec 2013
7	RMNCH+ consultant	Supporting RMNCH+A Activities of Koppal and Gadag	Koppal ,High Focused district	Dec 2013
8	RMNCH+ consultant	Supporting RMNCH+A Activities of Bijapur and Bagalkote	Bijapur ,High Focused district	Dec 2013
9	RMNCH+ consultant	Supporting RMNCH+A Activities of Raichur and Bellary	Bellary ,High Focused district	May 2014

The activities supported are mentioned below

RMNCH+A Activities supported:

1. Supported the launch of RMNCH+A at Gulbarga on 7 February 2014.
2. District level orientation of RMNCH+A strategy to District functionaries.
3. Supported the 5X5 Matrix translation, printing and ensured dissemination.
4. Gap Analysis of the 8 High priority districts with support from the St. John medical college
5. Block monitoring visits of the HPDs every month
6. Supported the DHAP activities

Other Activities Supported:

1. Supported in the PIP preparation activities of child health, Maternal health , PPTCT, Nutrition and IEC
2. Supported in the Activities of child health : Infant death review, SNCU evaluation, Pentavalent launch, Reports Analysis, SNCU software orientation
3. Supported in the new PPTCT guidelines, 100% testing of ANC, linking HIV positive mothers to ART centre, ensuring ART all positive mothers, integration of positive mother information into to the MCTS system.
4. Supported in the WIFS roll out, monitoring of NIDDCP activities, Vitamin A supplementation program, NRC and MNRC strengthening, IYCF trainings, supporting in the convergence activities
5. Supporting in the comprehensive IEC strategy and PIP of IEC for the state.

The activities which are being supported:

1. Ensuring RMNCH+A steering and operational committee meeting and action taken report
2. Ensuring the RMNCH+A district level monthly meeting in all the HPDs
3. SNCU software operationalisation in the entire state.
4. Ensuring labor room as per MNH tool kit
5. Block monitoring visits in all the HPDs and follow up on the identified gaps
6. Analysis and capacity building of maternal and infant death review
7. Strengthening of the NRCs and MNRCs
8. Vitamin A rounds monitoring and strengthening of poor performing blocks
9. Monitoring support of the WIFS program.
10. PIP preparation activities focusing of the High priority districts in forming a model labour room, upgrading the SNCUs, Supportive supervision of labour room.
11. Involvement of Medical Colleges, NGOs and other partners

Annex 4.1e

DEVELOPMENT PARTNERS		
Name of DP	Type of support provided viz. Infrastructure (Healthcare facility/wing, Funds, Human Resource, Drugs, Equipment, and Technical Support etc.)	
	Type of support	Location (District/Block/Village)
UNICEF	Technical support for RMNCH+A	State and District

3.2. DETAILED THEME WISE CURRENT STATUS AND SITUATION ANALYSIS:

Category / Type personnel												
	Regular		Contractual			Total in position (A+B+C)	Regular		Contractual			Total in position (D+E+F)
	Sanctioned	In position (A)	Sanctioned posts	In position through State /other (B)	In position from NRHM (C)		Sanctioned post	In position (D)	Sanctioned post	In position through State /other (E)	In position from NRHM (F)	
1st ANM	10025	8773	990	0	990	9763	3450	2099	375	0	375	2474
2nd ANM	0	0	0	0	0	0	0	0	0	0	0	0
MPW/ Male HW	5810	3500	0	0	0	3500	0	0	0	0	0	0
Staff Nurse	8554	5723	4323	0	4323	10046	1500	1007	1572	0	1572	2579
LHV/ PHNs	1556	1349	0	0	0	1349	0	0	0	0	0	0
LTs	3924	2837	149	0	129	2966	125	99	45	0	42	141
MOs	2193	656	80	0	70	726	97	36	40	0	14	50
Dentists/ Dental MOs	881	881	0	0	0	0	55	32	0	0	0	0
Specialists												
Gynaecologist	250	238	50	0	33	271	58	40	25	0	17	57
Anaesthetist	190	184	20	0	15	199	40	20	10	0	8	28
Paediatrician	200	185	45	0	41	226	47	17	20	0	17	34

Information Sheet on HR**A. Information on HR systems in the State**

		Yes/No
1.	Whether HR-MIS system is in place in the State?	Yes (HRMS)
2.	Whether the mechanism to regularly update the individual HR related information is in place?	Yes
3.	Has the facility wise HR information updated on State health/NHM website for public access?	State information is available in HRMS and HR under NHM is uploaded in website
4.	Is there a web-based system for distributing salary of regular employees in place?	Yes
5.	Is there web-based system for distributing salary of contractual employees in place?	Not for NHM contractual staff, but web based system is available contractual staff under state budget
6.	Are the staff working in High Priority Districts (HPDs) provided with differential salary than staff working in non-HPDs?	Yes for NHM contract staff
7.	Has State notified hard areas within the State?	Yes
8.	Does State provide for hard area allowance for employees in the notified areas?	Yes
9.	Are performance based incentives available for health care staff?	Yes
10.	Is there performance assessment system in place for regular as well as contractual employees?	Yes

B. Details of proposed salary hike in PIP (2014-15)

Has State planned for differential hike in salary based on performance assessment?

The process is on. Once the performance appraisal is completed differential salaries based on performance will be planned for 2015-16.

Staff productivity and performance appraisal

Introduction:

Qualified and motivated human resources (HR) are essential for adequate health service provision, but HR Shortages have now reached critical levels in many resource-poor settings, especially in rural areas. Strategies improving performance are essential to address shortages of the existing workforce. The policy-makers and planners are starting to realize that attaining the Millennium Development Goals (MDG) is simply not possible if the HR crisis is not more effectively addressed, despite the increase in financing for health care through debt release and specific programmes such as GAVI (Global Alliance for Vaccines and Immunization) and the Global Fund (Global Fund to Fight AIDS, Tuberculosis and Malaria).

Poor performance³ of service providers leads to inaccessibility of care and inappropriate care, which thus contribute to reduced health outcomes as people are not using services or are mistreated due to harmful practices. Poor performance is a result of health staff not being sufficient in numbers, or not providing care according to standards, and not being responsive to the needs of the community and patients.

In the past, staff performance was often perceived as a function of skills and knowledge. In recent years, it has been recognized that performance is influenced by additional factors if staff members are to perform to their full capacity, it is not only staffing issues that must be addressed, but also systems and facility issues. The performance of health workers depends not only on their competence (knowledge, skills) but also on their availability (retention and presence), their motivation and job satisfaction, as well as the availability of infrastructure, equipment and support systems, such as the management, information systems, resources and accountability systems that are in place

It is evident that poor health systems, with a lack of equipment, supplies and poor management structures, lead to poor productivity, limited competences and poor responsiveness. The root causes that result in suboptimal performance in these areas consist of a complex set of factors, which are interrelated. For instance, low salaries can lead to increased absence to earn extra income and also to decreased motivation to be willing to provide quality of care. At the same time, motivation is influenced by a lack of equipment, supplies, management support and supervision.

Factors influencing staff performance:

- Personal and lifestyle-related factors, including living circumstances;
- Work-related factors, related to preparation for work during pre-service education;
- Health-system related factors, such as human resources policy and planning;

- Job satisfaction influenced by health facility factors, such as financial considerations, working Conditions, management capacity and styles, professional advancement and safety at work.

Elements determine staff performance:

- 1) Availability
- 2) Productivity
- 3) Responsiveness
- 4) Competence

These four elements are influenced by retention, absence, motivation and job satisfaction, obtaining knowledge, skills and attitudes, accountability and working conditions, all interrelated. Absenteeism by health providers is a frequently occurring phenomenon in many health facilities, especially in resource-poor areas. Reasons for absenteeism may include income-generating opportunities elsewhere or personal problems.

Inadequate knowledge, skills and inappropriate attitudes can all form obstacles to good health care. Advances in insights into treatment and diagnosis, as well as changes in roles and responsibilities, require continuous professional development among health workers.

Performance appraisal system

Competency assessment:

Competency of health care providers in skills and knowledge is essential for quality health care out comes. Various studies have shown that the Competency levels of health care providers, especially ANM & staff nurse is suboptimal. The recent data released on IMR and service data from HMIS revels that whatever data fed in the HMIS is not translated into proportionate decrease in outcome indicators like IMR, MMR etc.

The need based competency assessment of health staff is highly essential for the improvement of quality health care services. This assessment will be focused on priority areas and after the assessment competency enhancement training is provided.

Strategies:

- Orientation training for state resource persons.
- Orientation training of district level assessment teams
- Knowledge and skill assessment at district level

Methodology:

- 1) Knowledge assessment using pre-designed questionnaires
- 2) Objective structured clinical examination.

The state has drawn a road map for assessing the skills and competencies of SNs and ANMs who are working at present in the Sub Centres, PHCs and CHCs and Sub District Hospitals. Competency will be conducted using a two-step method – knowledge assessment using pre-designed questionnaires and Objective Structured Clinical Examination (OSCE).

As a first step in this process State level trainers were trained Mumbai in November 2013. Thereafter State level TOT was organized where in district teams from ANMTC/DTC are trained. Now, in the ANM training Centres in 5 Districts (one in each Division), the exercise of skill and competency assessment based on questionnaire and OSCE will be undertaken by the trained teams. Assessment check list provided by MH division will be basic tool for this exercise. It will be ensured that the identified assessment site will have adequate logistics such as mannequins/ equipments/ AV aids required for all the skills listed for OSCE, consumable items/record papers for conducting assessment (eg. Gloves, Mask, apron, shoe covers, cap, pantograph copies, etc.) and adequate space for conducting skills assessments. This year it is proposed to assess only the SNs and ANMs working in Delivery Points.

It is planned to assess the skills in the following areas:

- Antenatal care
- Intrapartum care
- New born care
- Maternal complications
- Family planning

Skill and knowledge assessment was conducted for the first batch of front line health workers from three districts. Totally 22 staff nurses and junior health assistant female were assessed for the following

- 1) New born resuscitation
- 2) Hemoglobin estimation by salhi's method
- 3) Plotting and interpretation of partograph
- 4) Measuring BP
- 5) Interval IUCD insertion
- 6) AMTSL (Active management of third stage of Labour)

Along with the assessment knowledge assessment was conducted. Gaps were seen to maximum in partograph plotting interpretation and measurement of BP.

Referral Transport

The census report of 2011 has enumerated the population of Karnataka as 611.30lakhs. Currently, there is one ambulance for every 1.25 lakh population. The existing emergency norm is to have one ambulance for every 50,000 population. Accordingly the total ambulances work out to 1222 ambulances for the existing population. The experiences in the past has revealed that there needs to be at least 5% of buffer to take care of vehicles getting off road due to maintenance, vehicle service, accidents etc., Hence, the total vehicles required including the 5% buffer works out to 1283. At present there are 1019(517+502) ambulances thereby leaving a gap of 264 ambulances, which is under process of fabrication after which they will be inducted into fleet.

The goal of emergency medical services is to either provide treatment to those in need of urgent medical care, with the goal of satisfactorily treating the malady, or arranging for timely removal of the patient to the next point of definitive care. This is most likely a Casualty at a hospital or another place where physicians are available. The term Emergency Medical Service (EMS) evolved to reflect a change from a simple transportation system (ambulance service) to a system in which actual medical care occurred in addition to transportation.

EMS in Karnataka:

Today EMS in Karnataka is handled by

1. Government Ambulance Service.
2. Fire or Police Linked Services
3. Volunteer Ambulance Services
4. Private Ambulance Services
5. Combined Emergency Service
6. Hospital Based Service
7. Company Ambulances

The strategy developed for pre-hospital trauma care under EMS is based on the Golden Hour theory, i.e., that a trauma victim's best chance for survival is in an operating room, with the goal of having the patient in surgery within an hour of the traumatic event.

Today, this has moved up to the "Scoop and Run" treatment which is generally to transport the patient within ten minutes of arrival, hence the birth of the phrase, "the platinum ten minutes" (in addition to the "golden hour"), now commonly used.

Current scenario:

The current availability of ambulances in Karnataka is as follows:

Sl. No	Particulars	Nos.	OperationalDetails
1	State Owned Ambulances	577	Owned and operated by State Government
2	EMS –108	517+198	PPP Model with Government of Karnataka and GVK EMRI with 387 BLS and130ALS providing complete State of emergency services
3	DropBack Facility	200	Funded by NRHM, process of procurement is completed. These are exclusively for drop back under JSSK.

The EMS-108 scheme is equipped to handle emergency medical care and is operated through the common number '108'. There are 517 vehicles currently handling EMS across the state which include 130 ALS and 387 BLS. These vehicles are fully fitted with Advanced Vehicle Tracking System (AVLTS). There is a dedicated call centre to receive the emergency call. 108 is the emergency number dedicated for this service. These ambulances have EMTs and Drivers round the clock. They are equipped to handle medical emergencies.

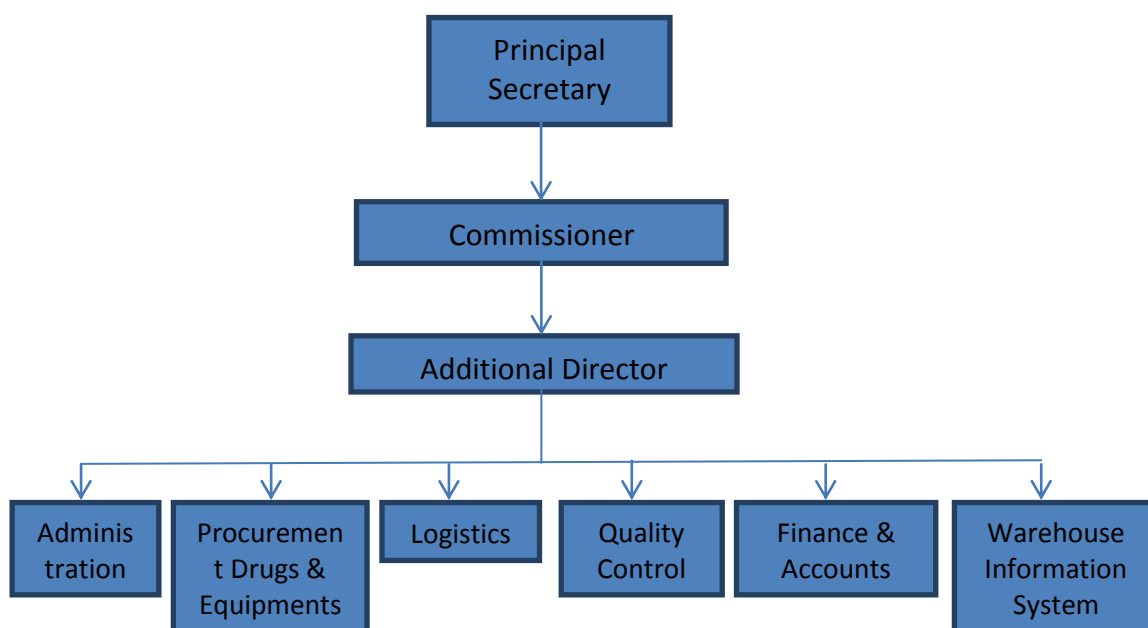
Apart from these there are 577 ambulances which are state owned which are also available for emergency case. These are stationed at CHCs, Taluk Hospitals and district Hospitals.

Procurement and Logistics

The erstwhile Government Medical Stores was catering to the needs of Institutions coming under the Directorate of Health & Family Welfare Services as well as the Directorate of Medical Education in the state. The process of purchases, storage and distribution of various Drugs & Chemicals was being carried out by the Government Medical Stores which was more a centralized function.

With an intentions to select, procure, store and distribute various categories of drugs in time to all the Health Institutions in a more scientific approach, thereby to ensure availability of right drug at the right time in the right proportion in the hospitals, Karnataka State Drugs Logistics & Warehousing Society was established with the assistance of European Commission to the tune of Rs.15.00 crores in the year 2002. The society was registered under Karnataka Registration Act on 28-3-2003 vide Registration No.172/03-04.

Organization Structure



In the first phase 14 Drug Warehouses are established with complete infrastructures like computers with internet connectivity, Warehouse operative equipments and manpower and are working smoothly. 13 more District Drug Warehouses with complete infrastructure in order to have better District wise access are constructed by KHSRDP and functioning.

In order to maintain cold chain facility to store certain important drugs and vaccine in each District Drug Warehouse and KDLWS Head Office, walk-in-coolers are established.

INDENT PROCESSING:

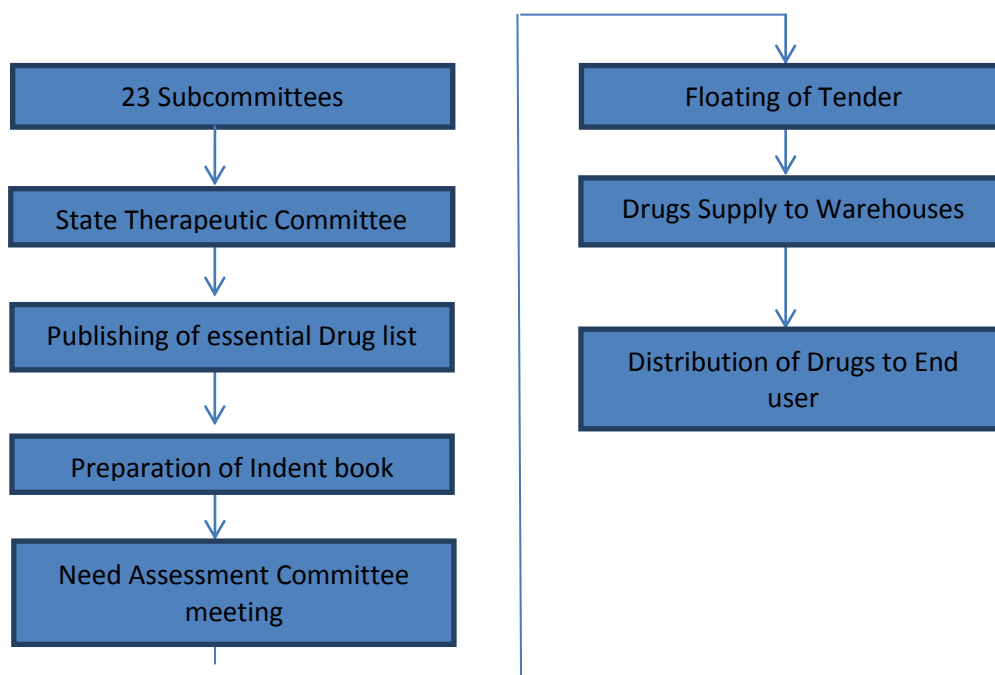
The annual drug indent books showing the list of drugs approved by state therapeutic committee will be supplied to the District Health & F.W. Officers, District Surgeons, Administrative Medical Officers of the hospitals and medical officers of PHCs through the respective District Drug Warehouses for submitting annual indent of the drugs.

Administrative Medical officers of the respective hospitals will submit indent to the District Drug Warehouse of the concerned District as per their budget.

The Warehouse In charge of the District Drug Ware House will consolidate the drug wise indent of all levels of Hospitals of the District and submit the district indent of drugs to the KDLWS through Ware House Information System (WIS)

The KDLWS will receive the District indents and consolidate the state level requirement of drugs. Final list of Drugs & its quantities are approved by Need Assessment Committee and the tender are floated.

Steps Followed in Drugs Procurement



E-PROCUREMENT PROCESS:

The K.D.L.W.S is working in coordination with the Centre for e-Governance, Government of Karnataka and has developed suitable e-procurement platform for procurement of Drugs, Chemicals, Medical Equipments, and other items.

The center for e-Governance has developed the following Modules and obtained approval of the Screening Committee.

1. Supply Registration
2. e-Tendering
3. Indent management.

The Government by an amendment to the KTPP Act has mandated KDLWS to go online for all procurement of drugs and other items having more than Rs. 50 lakhs estimated value.

Quality Check

Quality check will be done during the process of tender.

Quality check of Drugs supplied to Warehouses will be done through Empanelled Labs.

PROCUREMENT OF EQUIPMENTS & FURNITURES

The Procurement of Equipments and Furniture started from 2008.

As per the requirements of projects like NRHM, KSAPS, KHSRDP, KfW & NPCDCS/ NPHCE are procured and supplied to the institutions.

Quality Assurance

The quality assurance initiative in a focused and concrete form started in Tumkur district as a pilot project in the year 2007-08 under NRHM, which was focused mainly on MCH services in CHC/TLH, PHC and sub centers. It is extended to other districts in a phased manner and 18 districts were funded for this programme by NRHM and the remaining 12 districts by KHSDRP (World Bank Funded project). The assessment of the services at the District was carried out by a team of district level officer led by DHO and monitoring has been done by SPMU of KHSDRP since 2010-11. Parallely a team of officers have been constituted and functioning on the directions of Government of India to monitor family welfare services to ensure the standards for Female & Male sterilization as laid down are followed.

The funding for the expenditure of quality assessment at the District level has been taken over by KHSDRP since June 2011. To rationalize the quality assessment activities of the districts, the District Quality Assurance Group is constituted. This committed reviews various quality assessment activities of health care service delivery required to be performed in the district.

A. District Quality Assurance Group will undertake the following assessment:

1. Health Care Service Delivery

- a. Quality Assessment Sub Centres, Primary Health Centres, Community Health Centres and Taluk Hospitals/Taluk level Hospitals, as per the assessment formats derived by the State Quality Assurance Cell/Board.
- b. Documentation and analysis of assessment data and submission of report to the State Quality Assurance Cell/Board.
- c. To guide and mentor improvement in the service delivery of the institutions based on the assessments done.

2. Sterilization Services

- a. Medical audit of all deaths in the district due to sterilization and submission of report to State Level Quality Assurance Committee.
- b. To collect, review and report the details of cases where problems were encountered during or after the sterilization procedure and cases of sterilization failure.
- c. To assist and facilitate the submission of claims within 90 days, to the designated Insurance company following sterilization failure, complication due to sterilization or death due to sterilization, after careful and diligent examination.
- d. To monitor the quality of sterilization services rendered by government and non-government organizations in institutions and camps, and suggest ways to improve quality.
- e.

B. Constitution of the District Quality Assurance Group

i. District Health & Family officer	- Chairperson
ii. District Surgeon	- Member
iii. Principal, District Training Centre	- Member
iv. All District Programme officers	- Member
v. District Project Management officer	- Member Secretary
vi. All Taluk health Officers	- Member
vii. Supervisory staff of the district	- Member
viii. NGO representatives	- Member

C. Functioning of DQAG on Health Care Services Delivery assessment

- The team assessing a TH or a CHC will have minimum of four members specified in Para B above.
- The team assessing a PHC or a SC will have minimum of three members specified in Para B above.
- The DPMO as a Member Secretary of DQAG will plan and monitor the visits, and submission of physical and financial reports every month to the State QA Cell.
- The District Quality Assurance Cell will function in the office of the District Project Management Unit, and will facilitate all QA activities including conduct of meetings, trainings, visits, reporting, data compilation and analysis.
- The DPMO will ensure adequate separate office set up including and assistant cum computer operator for smooth functioning of QA Cell.

D. Functioning of DQAG on Sterilization Services

The DQAG will report to the District Level Quality Assurance Committee comprising of the following, in all cases of Sterilization Services as per Government of India Notification.

i. Deputy Commissioner	- Chairman
ii. District Health & Family Welfare Officer	- Convener
iii. District Family Welfare Officer / Dist. RCHO	- Member Secretary
iv. Empanelled Obstetrician	- Member
v. Empanelled NSV Surgeon	-Member
vi. Senior Anesthetist	-Member
vii. District Nursing Officer	-Member
viii. Public Prosecutor	-Member
ix. Representative from women welfare organization	-Member

The DQAG will carry out the assignments as per the plan. The facility assessment is done on the basis of prescribed check list, which includes various indicators - infrastructure details, functioning of equipment's, OPD and IP management and other services related to RCH, FW and other para meters. Grading (A, B, C & D) of the health facilities is done based on the scoring.

Monitoring and evaluation including HMIS and MCTS

HMIS (Health Management Information System) is an initiative undertaken under the National Health Mission (NRHM) launched by Government of India.

To collect the information uniformly timely from all the states, Government of India has prescribed HMIS formats throughout the country. The System of collecting information uploading online at the primary level & to get various reports by compiling the information for effective implementation of Health Schemes is Health Management Information System.

In Karnataka uploading of Information on HMIS portal from facility level is happening since Aug 2010. This has facilitated in getting timely information at ease. Reports are being generated at all levels right from the sub center to District level. This was done manually prior to HMIS, but now the data is transferred electronically. These help in planning various schemes & monitor their implementation.

Currently there are 87 data elements on which data is captured from sub center, 140 data elements at PHC, 156 from CHC/SDH/DH. The online data updation is done before 5th of every month. Since the data elements are too huge and number of data feeding centres is more it has taken time to optimize the quality of data.

MCTS

To bring down Maternal Mortality Ratio (MMR) & Infant Mortality Rate (IMR), it is essential to provide essential services to pregnant women & child. To keep track of every pregnant woman registered till her delivery and follow up children born until they complete immunization, Mother & Child Tracking System (MCTS) was introduced.

The State is implementing MCTS Technology in co-ordination with NIC, Bangalore since Jan 2011.

Information available in MCP (Thayicard) cards provided to all pregnant women is uploaded in MCTS Portal. Providing information to ANM regarding the services to be given to pregnant women in the prescribed time & sending SMS to the beneficiary as to which service she has to avail and when & uploading the services provided to pregnant women & child by sending SMS to the MCTS Portal. Apart from this MCTS allows to creating work plan to ANM regarding services to be given to PW & child so that the activities of the ANM can be monitored by any officer at all levels.

Convergence & Partnership

Convergence and partnership with various stakeholders will be strengthened in order to achieve public health goals and to make health services available to the community, particularly to the underserved segment of the population.

Convergence framework is established with various Disease control programmes, Non-communicable diseases, AYUSH, National Aids Control Programme, NUHM, Adolescent Health, Maternal Health & Child Health etc. Under NHM framework all these components are brought under single umbrella.

Appropriate linkage is already established with other sectors like Women & Child Development Department, Education Department, Department of Rural Development, NirmalBharathAbhiyan, IGMSY(Indira Gandhi MatritvaSurakshaYojana), Labor Department and Panchayatraj Department. Linkages with ICDS is integral to RMNCH+A approach, where Nutrition and early child development are integral to child survival and Maternal Health. Various committees are working at district level and block level, which involves other sectors officials. The public health goals and expected outcomes are achieved with involvement of various department and partnerships.

The NGOs play a significant role in the implementation of various health activities in the community. The technical partners will support and assist integrated programme implementation and monitoring in the selected districts.

The Private sector practitioners provide more than 40% health care services to the community. Hence contribution of resources from the private sectors has a crucial role to play in ensuring the health care services. The PIP activity plan involves partnership activities like Mobile Health Clinics, Citizen Helpdesk, contracting-in specialist services. Out sourcing of specialist services, laboratory services etc.

Private Health sector and corporate sector are involved in providing Tertiary care services under VajapayeArogya Shree for SC/ST, BPL families and Rajiv ArogyaBhagya scheme for APL families.

Community processes

The NRHM was launched on the 12th April 2005 with the goal of improving the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, Women & Children. In order to ensure that the services reach those for whom they are meant the NRHM proposes an intensive accountability frame work that includes community based monitoring as one of the key interventions.

The accountability frame work proposes includes:

- Internal monitoring
- Periodic surveys
- Studies and community based monitoring

Community monitoring is an important aspect of promoting community led actions in the field of health. It empowers the community member, community based organizations, local committees and PRIs to systematically provide feedback on how the health system is performing.

Objective:-

The main objective of community based monitoring is to improve accessibility of quality health care services to the people residing in rural areas, poor and vulnerable groups.

Strategies:-

- Involvement of Women systematically at community level
- Establishment of accountability framework mechanism
- Involvement of VHSNC and ARS
- Social audit and communitisation efforts at PRI level
- Utilization of VHNDs as a platform for assured services

Process of community monitoring:-

It involves planning, activating, motivating, capacity building and allowing community and its representatives to directly give feedback about the functioning of public health services, including giving inputs for improved planning of the same.

The community and community based organizations will monitor demand/need, coverage, access, quality, effectiveness, behavior and presence of health care personal at the service points, possible denial of care negligence.

The monitoring process will include:

- 1) Outreach services
- 2) Public health facilities
- 3) Referral systems

The entire process of community monitoring is implemented as a partnership between the health department and civil society organizations. This process will supervise at state level and district level and also at national level.

In Karnataka various activities are planned for community participation at various levels:-

- VHSNCs and PRIs are involved in the preparation of village health plans and district health plans.
- Community health day is celebrated in all the health facility throughout the state where social auditing of the health facility is done by the community members.
- Various committees are formulated at State level, district level and facility level for community participation.
- Orientation trainings are being conducted for VHSNC, ARS and other NGO partners
- Periodic community monitoring at village, PHC, Taluk& District levels

- Fixed day village health & nutrition days are conducted in all the villages, which is a platform for assured and predictable package of outreach services. In Karnataka totally 430421 meetings are conducted as on December 2013.

Community participation at various levels in Karnataka:-

- **At village level:** VHSNCs will carry out community planning and monitoring and they will prepare village health plan and village report card
- **At PHC level:** ARS are constituted at facility level, these committees will review the performance and plan for the development of the facility. They will prepare PHC plan
- **At Taluk level:** Taluk community planning and monitoring community is formed at taluk level this committee will carry out community planning and monitoring at taluk level.
- **At District level:** District community planning and monitoring community is formed at District level this committee will carry out community planning and monitoring at District level.
- **At State level:** State community planning and monitoring community are formed at State level this committee will carry out community planning and monitoring at State level. This committee will serve as a subcommittee to the State health mission.

The Government of Karnataka has issued various guidelines and GOs regarding formation of community planning and monitoring committee.

Programme Management

The State Programme Management Unit (SPMU), 30 District Programme Management Units (DPMU) and 176 Block Programme Management Units (BPMU) have been established to support & augment the programme management capacity of NRHM. These units strengthen the existing management structures at the State, district and block levels respectively and form an integral part of NRHM.

The State Programme Management Unit (SPMU) functions as the secretariat at state level for NRHM & has two units namely the Administrative Unit and the Financial Unit or the Finance Management Group (FMG). Presently Chief Administrative Officer, who heads the administrative unit, is from the Karnataka Administrative Services (Senior Scale).

The Finance Management Group (FMG) as per conditionality of GOI is to consist of a Director (Finance & Accounts), State Finance Manager (SFM), State Accounts Manager (SAM), Accounts Assistants and other support staff. Presently, an officer from the Karnataka State Accounts Services (Joint Controller Cadre) is working as Chief Finance Officer (CFO).

Similarly, The State Finance Manager (SFM) is held by an Officer from the Group A - State Accounts Services. The State Accounts Manager (SAM) until 2011 was occupied by contractual staff. Consultant who has been hired under the Karnataka Health Systems and Reforms Project is holding the additional charge of SAM.

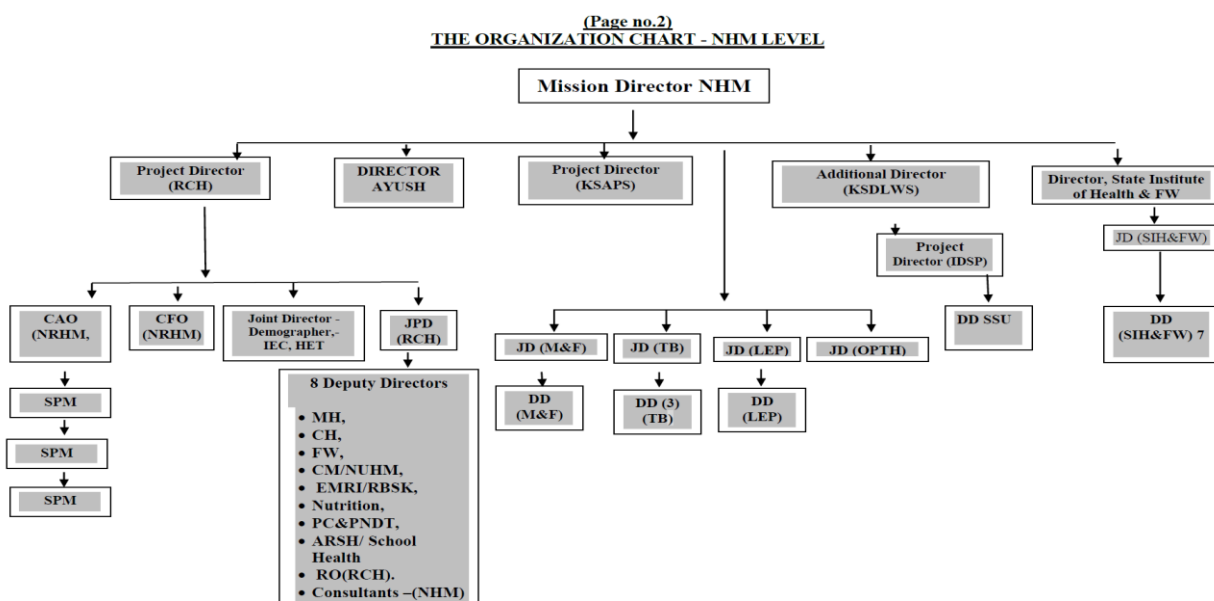
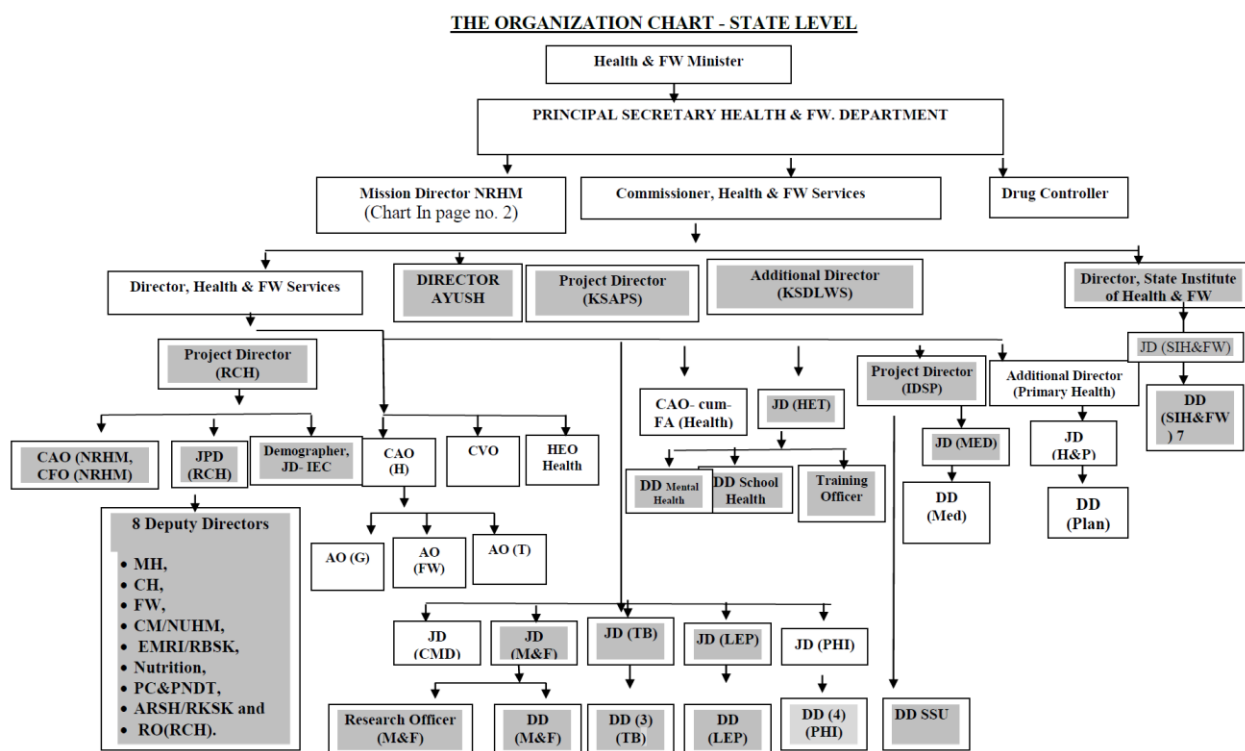
The lateral infusion of professionals on contract has been a major initiative towards improving management of health programmes under NRHM. However, unlike programmatic component, finance management and Government accounting has its own uniqueness with a high degree of accountability. The continuum of knowledge and system strengthening is possible with having permanent staff at these key positions. The key advantages are:

- a) Augmenting the institutional memory.
- b) Internalization of NRHM by Department of Health and Family Welfare Services, Govt of Karnataka.
- c) Enhanced accountability within the system.

The budget provision for the posts of State Finance Manager and State Accounts Manager was approved in the ROP of 2013-14 under A 10.1: Strengthening of State Health Society. The post of Chief Administrative Officer from the Karnataka Administrative Services has been approved to be taken on deputation under A.10.1.10, on similar lines administrative approval is sought to obtain the services of Director (Finance), SFM and SAM from State Accounts Department.

The clerical / ministerial support staff is essential to support the key personnel of FMG. The availability of better job opportunities in IT and ITES sectors has resulted in higher level of attrition among the accounting support staff. This has resulted in increased pressure on the system as the new recruits have a learning curve and take time to obtain a grip on the nuances of the programme. Hence it is proposed to have four clerical / ministerial support staff on deputation from Department of Health and Family Welfare Services for assist and support the FMG.

Detailed organization Structure and Staffing both Directorate and PMU at State, district/City and block level



Supportive supervision

Supportive supervision is one of the important major interventions to monitor the programme implementation. It is identified as a one of the bottle neck in improving the performance of health staffs and in delivering quality services. Supportive supervision within the health care context implies regular and dependable interaction between health provider and a more experienced professional. It helps to identify and solve problems, improve services and advance skills and knowledge.

Objective:-

The main objective of supportive supervision is:-

- To provide quality health care services
- To improve skills and knowledge of health personal
- To improve the integration of primary health care services

Key challenges in providing supportive supervision:-

- Shortage of health supervisors within the system
- Lack of supportive skills
- Restricted mobility of supervisors for field supervision
- Lack of guidelines for supportive supervision and supervision policy
- Vertical programme with vertical supervision leads to fragmentation

Strategies:-

- Development of supportive supervision policy with clear cut guidelines
- Preparation of micro plan
- Development of tools for supportive supervision
- Training and capacity building

Government of Karnataka has taken various steps to strengthen the supportive supervision of front line health workers and service providers

- 1) **Nodal officer visit:** Deputy Director cadre state officials are nominated as a nodal officer for each district. These nodal officers regularly visit designated districts every month. A supportive supervision check list is designed for nodal officer visit and it is used for the supportive supervision.
- 2) **Tools for supportive supervision:** Check list has been developed and published in the website; there is a plan for each officer from state to PHC level for supportive supervision.
- 3) **Training and capacity building:** All the nodal officers and Districts programme officers are trained at state level and district level respectively

Approach:

- 1) **Supportive supervision of health facilities:** This is mainly focused on delivery points, low performing sub centers, 24X7 PHCs, CHCs, TLH and districts hospitals.
- 2) **Supportive supervision of front line workers:** This includes ASHA, ANM, LHVs etc.

Clear cut long term and short term plans, checklist and guidelines are developed as tools to guide the supervisors.

Plan of field visits for supportive supervision

<i>Level</i>	<i>Person responsible</i>	<i>Minimum frequency of field visit</i>
PHC	Senior Health Assistant (Female)	At least 3 days/ week, to one SC per visit Every SC will be covered twice a month At least 1 VHND/ Week
	Medical Officer – PHC	At least twice a month to 2 weak performing SCs/ANMs and 2 VHNDs/ Month
CHC	Block MO-I/C	At least twice a month to 2 weak performing PHCs and 2 weak performing SCs
	Block Programme Manager	At least twice a week i.e. 8 times in a month 2 SCs /Outreach and household assessment per visit OR 1 PHC and 1 SC/outreach and household assessment per visit
District	DNO	At least twice a week i.e. 8 times in a month 1 PHC and 1 SC per visit OR 2 SCs, 1 outreach and household assessment per visit
	DH & FWO	At least twice a month to any weak performing facility and outreach
	District Programme Manager	At least once a week i.e. 4 times in a month 1 CHC and 1 SC per visit OR 2 PHCs and 1 SC per visit OR 1 PHC, 1 SC, 1 outreach and household
	RCHO/DPMO and other technical officers	At least once a week i.e. 4 times in a month 1 CHC and 1 SC per visit OR 2 PHCs and 1 SC per visit OR 1 PHC, 1 SC, 1 outreach and household
State	Mission Director	At least twice a month to one poor performing district per visit, Ideally 1SC, 1PHC and 1 CHC/DH to be visited per visit
	State Programme Manager	At least twice a month to one poor performing district per visit. Ideally 1SC, 1PHC and 1 CHC/DH to be visited per visit
	Senior Officers of State Directorate	At least twice a month to one poor performing district per visit. Ideally 1SC, 1PHC and 1 CHC/DH to be visited per visit

Programme/Health outcomes: Current status, Trends and Key challenges for:

INDICATOR	INDIA		Karnataka			STATE TARGETS		
	Current status	NHM goal	Trend (year & source)			2014-15	2015-16	2016-17
Maternal Health								
Maternal Mortality Ratio (MMR) (SRS 10-12)	178	100	213	178	144	130	115	< 100
Child Health								
Under 5 Mortality (SRS 2012)	52	38	45 (SRS-2010)	40 (SRS-2011)	37 SRS-2012)	33	30	27
Infant Mortality Rate (IMR) (SRS 2012)	42	25	38 (SRS-2010)	35 (SRS-2011)	32 (SRS-2012)	29	26	23
Neonatal Mortality Rate (NMR) (SRS 2012)	29	NA	25 (SRS-2010)	24 (SRS-2011)	23 (SRS-2012)	22	21	20
Early NMR (SRS 2012)	23	NA	22(SRS-2010)	20 (SRS-2011)	20 (SRS-2012)	19	18	17
Family Planning								
Total Fertility Rate (TFR) (SRS 2012)	2.4	≤ 2.1	1.9 (SRS-2010)	1.9 (SRS-2011)	1.9 (SRS 2012)	1.9	1.8	1.8

Indicators	Trend (year & source)			State Targets		
	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
MATERNAL HEALTH						
Topline indicators						
Maternal Mortality Ratio	213 (SRS 2004-06)	178 (SRS 2007-09)	144 (SRS 2010-12)	130	115	< 100
Service delivery						
4 ANC's	1463352	1493107	1339138	4295597	1300000	1350000
Institutional Deliveries (out of the total estimated deliveries) to be conducted in Public health institutions (HMIS)	72.67	72.26	69.74	80	85	88
Delivery Points						
DHs	NA	38	39	39	39	39
CHCs and other health facilities at sub district level	NA	262	271	280	300	320
24*7 PHCs and Non FRUs & non 24x7 PHCs	NA	629	522	575	600	650
SCs	NA	50	57	70	90	100
CHILD HEALTH AND IMMUNISATION						
Topline indicators						
E-NMR	22(SRS-2010)	20 (SRS-2011)	20 (SRS-2012)	19	18	17
NMR	25 (SRS-2010)	24 (SRS-2011)	23 (SRS-2012)	22	21	20
IMR	38 (SRS-2010)	35 (SRS-2011)	32 (SRS-2012)	29	26	23
U5MR	45 (SRS-2010)	40 (SRS-2011)	37 SRS-2012)	33	30	27
Service delivery						
Fully immunized children by age of one year	1133816 (HMIS)	128233 (HMIS)	1073023 (HMIS)	1132794 (HMIS)	1157616	1174520
FAMILY PLANNING						
Topline indicators						
Total Fertility Rate (TFR)	1.9 (SRS-2010)	1.9 (SRS-2011)	1.9 (SRS 2012)	1.9	1.8	1.8
Service delivery						
IUCD - Total	195487 (HMIS)	189981 (HMIS)	168030 (HMIS)	325000	350000	375000
Female Sterilization (in nos.)	309285 (HMIS)	258878 (HMIS)	223312 (HMIS)	250000	300000	350000
Male sterilization	3894 (HMIS)	2857 (HMIS)	1654 (HMIS)	4070	5000	6000

PCPNDT						
Topline indicators						
Improvement in child sex ratio at birth	946 (census 2001)	948 (census 2011)	948	950	952	955
Disease Control (Departmental data)						
ABER for malaria (%)	15.9	16.2	15.3	>15	>15	>15
API for malaria (per 1000 population)	0.4	0.3	0.23	<0.2	<0.2	<0.2
Annualized New Smear Positive Detection Rate of TB (%)	64%	69%	0.56	0.7	90%	0.9
Success Rate of New Smear Positive Treatment initiated on DOTS (%)	82.5%	0.83	0.83	85%	90%	90%
Cataract operations(lakhs)(Departmental data)	3.47	3.88	3.64	3.90	4.20	4.50
Leprosy Prevalence Rate(Departmental data)	0.45	0.46	0.45	0.42	0.41	0.40
No. of outbreaks reported under IDSP in past year	226	223	314	176	170	150

Annex 6.2

CONDITIONALITIES& INCENTIVES

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
CONDITIONALITY				
1. Rational deployment of HR with the highest priority accorded to high priority districts and delivery points		Approval of budget for HR beyond Sept 13 to be withheld		
<p>1.1 Comprehensive Rational deployment policy which would inter alia include:</p> <p>Filling up of vacancies in high priority districts</p> <p>Rational deployment of EmOC and LSAS trained doctors and specialists especially gynaecologists and anaesthetists in teams</p> <p>Posting of staff on the basis of case load (OPD/IPD/Normal deliveries/C-sections).</p>	In place by 10 September, 2013		<p>Policy notification (copy) / G.O) and Website posting; state report on compliance by 15th Sept, 2013. As a minimum, policy/ G.O must address aspects highlighted in 1.1.</p>	<p>Filling of Vacancies:</p> <p>Government of Karnataka has taken many steps to fill the vacancy in the high priority districts and also in all the districts. Process is already initiated to fill the vacancies of all cadre posts vide Gazette Notification No: SRC/14A/2011-12. Dated: 5-12-2012, revised 29-10-2013, G O No. SAMVYASHAE/03/SHASANA/2011. Dated: 27-04-2011, G O No: HFW/332/HSM/2012, Dated: 19-02-2013. As on January 30th 2014 the following vacancies are filled with permanent recruitment:</p> <p>Junior Health Assistant Male -314</p> <p>Junior Health Assistant Male(Backlog) – 107</p>

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
				<p>Pharmacist ((Backlog) – 16 Group D – 2323.</p> <p>As regarding recruitment for other cadres, namely - Junior Health Assistant Female -735, Group D NLEP – 100, Para medical posts – 450, Drivers – 318, GDMOs – 331, Other Para medical staff -3763, Micro biologist – 27, BHEOs – 145, Lab technician – 87, Specialists Doctors – 983 and Dental Medical officers – 87 the approval is pending at Government level because of Article 371 (J) of constitution and framing of rules for the same.</p> <p>Rational deployment of EmOC and LSAS trained doctors and specialist</p> <p>State has shown good progress in rational deployment of EMoC and LSAS trained Doctors. Totally 70 Doctors have been trained in EMoC and 74 in LSAS and out of which 24 and 23 respectively are conducting C-section and administering lifesaving anaesthesia</p>

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
				<p>Further State has taken following steps to fill the specialist vacancy in High Focused Districts.</p> <p>In service candidates have done post-graduation are posted on priority basis to high focused Districts.</p> <p>Posting of staff on the basis up case load</p> <p>A systemic and elaborate exercise was under taken based on the case load of the health facilities to re deploy contractual staff nurses working in the 24X7 PHCs. As a result of this exercise a total of 429 staff nurses in the State have been re deployed to delivery points will high case load.</p>

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
1.2 Preparation of baseline data for HR (in particular, specialists, MOs, SNs, ANMs and Lab techs) including the current place of posting; system for updation(e.g. frequency/ when transfer/ posting orders are issued).	In place by 10 September, 2013. State report on compliance by September , 2013.		Website posting of updated HR: as a minimum for specialists, EmOC and LSAS trained doctors and MOs List of delivery points not having adequate staff and list of facilities having excess staff to be furnished.	Preparation of baseline data for HR Facility wise details of all services are available for all health facilities from PHC upward on the State NRHM website. Further details of contractual staff in each facility can also be seen in the data sheet on facility audit. www.karhfw.gov.in/nrhm/mandate.aspx
1.3 Evidence of corrective action in line with the policy	All delivery points in HPD staffed in line with norms by 10 September, 2013;		All the delivery points to be fully staffed (preference to be given to HPDs) Minimum 50% of the EmOC and LSAS doctors (posted in lower level facilities as per March 2013	All details pertaining to delivery points and contractual staffs working is available on the State NRHM website www.karhfw.gov.in/nrhm/mandate.aspx

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
			baseline) to be posted in appropriate facilities List of EmOC and LSAS trained doctors, place of posting and C-sections conducted to be posted on website. Corrective action taken / compliance report to be uploaded on website by September 2013.	
2. Facility wise performance audit and corrective action based thereon.		Approval of budget for HR beyond Sept 13 to be withheld		
2.1 Facility wise reporting (infrastructure sheet and facility	By 10 September,		Review of HMIS ; June data to be	Facility wise details of services available in health facilities is available on the

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
wise data) on HMIS portal by all facilities as a minimum for all HPDs (SC data if needed be uploaded from PHC)	2013		uploaded by end of August,2013	State NRHM website.
2.2 Action plan in place for corrective action based on facility rating	By 10 September, 2013		Action plan to be uploaded on website	Infrastructure sheet for health facilities is uploaded in the HMIS web portal. This includes details of Sub Centre, PHC, CHC, TLHs, DHs and DLHs. State Nodal officers for each district visit the health facilities in the Districts every month and take necessary steps to improve the facility performance. Supervision and monitoring visits are planned at District level, Taluk level, PHC level at regular intervals.
2.3 Corrective action (as a min in HPD) taken.	By November, 2013		State reports on corrective action by November, 2013	
3.Performance Measurement system set up and implemented to monitor performance of regular and contractual staff		Approval of budget for HR beyond Sept 13 to be withheld		
3.1 System for performance measurement of regular and contractual staff in place.	By 10 September, 2013		Performance measurement system	Performance Measurement system

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
			description and government order to be uploaded on website. State compliance report.	<p>This is a work in progress. All the District Programme Managers (DPM) working in the State have been enrolled for online course on Programme Management Support Unit (PMSU) through e-learning platform conducted by NIHFV. Continuation of contract as well as salary hike in F/Y 2014-15 will be contingent on the DPMs successfully completing this course. Through the Institute of Public Health (IPH),</p> <p>a similar course is organised for the BPMs. Further, the performance of DPMs and BPMs will be assessed at the end of the year based on clearly drawn criteria which have been prepared which will be basis for any salary hike. Thus, there will be no automatic continuation of contract or salary hike for these staff as was the case in previous years.</p> <p>Other staff such as Programme Assistants, etc would also undergo basic knowledge, skills and attitude</p>
3.2 Baseline performance targets set for all regular and contractual staff and shared	By 10 September, 2013		To be uploaded on website	
3.3 Performance reviewed and action taken in line with the performance measurement system.	By March, 2014		State Compliance Report	

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
				<p>assessment through an examination before their contracts are renewed. As regards SNs, ANMs etc, baseline assessment of competencies will be undertaken for those who are working in delivery points and contract renewal will be automatically done for those who have scored well in the baseline assessment. For those who are weak in competences, training would be organized following which a repeat assessment will be made. If scores still continue to be low, then contracts will not be renewed for such SNs and ANMs. For those who are working in non-delivery points, clearly drawn performance assessment criteria have been prepared which will form the basis of contract renewal and salary hike in 2014-15.</p> <p>State does not propose to undertake any performance assessment for staff that has been hired through outsourcing agencies such as Data</p>

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
				Entry Operators, Drivers and Group D etc as this is an elaborate and time consuming exercise and it is very difficult to draw performance criteria for such staff. Continuation of contract will be based on assessment by the officer with whom such staff is working. Salary hike would be eligible for staff that has performed satisfactorily as per assessment of the supervisory officer.
4. Baseline assessment of competencies of all SNs, ANMs, Laboratory technicians to be done and corrective action taken thereon		Approval of budget for HR beyond Sept 13 to be withheld		
4.1 Baseline assessment conducted and staff appropriately graded	10 September, 2013		Baseline assessment plan of action developed and action initiated and results (district/block wise summary table for staff	Baseline assessment of competencies of all SNs, ANMs, etc: The State has drawn a road map for assessing the skills and competencies of SNs and ANMs who are working at present in the Sub Centres, PHCs and CHCs and Sub District Hospitals. Competency

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
			graded on competencies) available on website by February, 2014	assessment will be conducted using a two-step method - knowledge assessment using pre-designed questionnaires and Objective Structured Clinical Examination (OSCE). As a first step in this process State level trainers were trained in Mumbai in November 2013. Thereafter State level TOT was organized wherein District Teams from ANMTC/DTC are trained. Now, in the ANM training Centres in 5 Districts (one in each Division), the exercise of skill and competency assessment based on questionnaire and OSCE is being undertaken by the trained teams. Assessment check list provided by MH Division will be basic tool for this exercise. It is being ensured that the identified assessment site will have adequate logistics such as mannequins/ equipments/ AV aids required for all the skills listed for OSCE,
4.2 Action plan with time line to show improvement in staff competencies in place	September 2013		Action plan uploaded on website	
4.3 Progress in implementation of plan. E.g. % target group trained	December 2013		Compliance report by March, 2014	

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
				<p>consumable items/record papers for conducting assessment (eg. Gloves, mask, apron, shoe covers, cap, partograph copies, etc.), and adequate space for conducting skills assessments. This year it is proposed to assess only the SNs and ANMs working in Delivery Points. The first batch of skill assessment of service provider (Staff nurses and Junior Health assistant female) was done on 28-12-2013 at SIHFW Bangalore. Three Districts were selected for assessment and 22 Health care providers' skills were assessed, for the following skills:</p> <p>N born resuscitation. Hemoglobin estimation by Sahli's method. Plotting and interpretation of partograph Measuring BP Interval IUCD insertion AMTSL(Active management o third stage of Labor)</p>

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks		
				The timetable for undertaking assessment for this F/Y is as given below:-		
				Sl. No.	Date of Training	Batches from Districts
				1	09-01-2014 to 10-01-2014	Chitradurga, Bagalkote, Chamarajanagar, Davanagere, Kodagu, Hassan.
				2	16-01-2014 to 17-01-2014	Gulbarga, Bijapura, Raichur, Bidar, Dharwad.
				3	30-01-2014 to 31-01-2014	Belguam, karwar, Mangalore, Udupi, Kolar, Shimoga
				4	06-02-2014 to 07-02-2014	Tumkur, Chikkaballapura, Mandya, Ramanagar, Mysore, Chikkamagalore.

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks		
				5	13-02-2014 to 14-02-2014	Bangalore (U), Bangalore (R), Gadag, Yadgir, Koppal.
				First batch of TOT training for 14 members and 2 nd batch of TOT training 30 members has been completed.		
5. Gaps in implementation of JSSK		(Non compliance may lead to a reduction in outlay upto 10% of RCH base flexi-pool.)				
5.1 State wide dissemination of GO/policy; visible IEC in facilities and community awareness.	By Sept 2013		Sample community visits/ IMT visits /survey show high awareness.	All the entitlement programmes such as JSY, JSSK are permanently displayed in all the Health facilities, Gram Panchayat and prominent places in the Urban area and Rural area.		
5.2 No user charges for pregnant women and newborns. Drugs, diagnostics, diet should be available free. Grievance redressal system operational	By October 2013		End user survey, grievance redressal records.	Sample verification is established through nodal officer's visit and supervisory visits at various levels. Grievance redressal system is in place and operationalized through 104 help line and citizen help desk at Districts Hospital and major Hospitals.		

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
INCENTIVES				
1. Responsiveness, transparency and accountability (incentive upto 8% of MFP).		Up to 8% of MFP		
1.1 Demonstrated initiatives including innovations for responsiveness in particular to local health needs e.g. use of epidemiological data, active participation of public representatives in DHS / RKS meetings, involvement of local charitable organizations/NGS etc.	Initiative / Innovation implemented and impact demonstrated; State to send brief report in line with format provided in Annex 1 by November, 2013. (3 best practices , preferably one in each of 3 areas)		State report (format in Annex 1) by September, 2013; state visits for rapid appraisal.	
1.2 Demonstrated initiatives /innovations for transparency e.g. mandatory disclosures and other important information including HR posting to be displayed on State NRHM website, schedule of MMUs and RCH camps etc. to be disseminated among user groups in addition to these being displayed in the State NRHM websites etc.				

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
1.3 Demonstrated initiatives /innovation for accountability: e.g. call centre for integrated grievance handling system, aggrieved party to receive sms with a grievance registered number; action taken within stipulated time; community monitoring; Jan sunwai etc.				
2. Quality assurance (incentive upto 3% of MFP).		Up to 3% of MFP		
2.1 States notify quality policy/strategy (align to national policy) as well as standards	In place by October 2013		Notification and state report by October, 2013.	The Quality Assurance initiative in a focussed and concrete form started in Tumkur District as a pilot project with focus on MCH services in CHCs, PHCs and SCs in 2007-08, under NRHM. It was expanded to include all districts in a phased manner by 2010-11. 18 districts were funded for this programme by NRHM and the remaining 12 districts by KHS DRP.
2.2 Constitute dedicated teams. Training of state and district quality team and DH quality team completed.	State team trained by October 2013			
2.3 Current levels of quality measured for all "priority facilities" and scored and available on public domain. Deadlines for each facility to achieve quality standards declared.			Quality scores of all priority facilities available in public domain.	The assessment of the services at the district was carried out by a team of district level programme officers led by

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
				<p>DHO and monitoring has been done by SPMU of KHSDRP since 2010-11.</p> <p>To rationalise the quality assessment activities of the district, it is decided to constitute a District Quality Assurance Group, bringing under its purview various quality assessment activities of health care services delivery required to be performed in the district.</p> <p>In this regard G O is issued vide No: HFW/KHSDRP/PHCF/QAP/42/2010-11: dt: 20-06-2011 and G O number</p> <p>HFW/KHSDRP/QA/DQAG/10/11-12; BANGALORE, Dt: 24-05-2012.</p> <p>As per the G O District quality assurance Group is constituted and framed the functioning of DQAG (District quality assurance group).</p> <p>Various indicators are framed to assess the Health facilities – Infrastructure – 23, OPD management – 10, Maternal care – 4, Immunization – 7, wound management – 7, In patient care – 6, preventive care – 12, Family planning</p>

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
				9, other services – 6. The facility grading is done by calculating Service Quality Index (SQI).
3. Inter-sectoral convergence (incentive up to 3% of MFP).		up to 3% of MFP		
3.1 Implementation frame work for intersectoral convergence with allied sectors/departments	By October 2013	Up to 1% of MFP	State report (copy of implementation framework)	Anganwadi Health check-ups of School health programmes are planned, implemented and monitored in association with WCD, PHED, Education departments in Karnataka all the Health Programmes are implemented with involvement of Panchayat raj institutions.
3.2 Intersectoral convergence opportunities identified with WCD, PHED, education, etc. and action initiated.	By October 2013	Up to 2% of MFP	Government order , State report	Various committees are formed at State level, District level with involvement of WCD, PHED, education, etc. And programme implementation is reviewed under the chairmanship of DC and CEO-ZP. In this regard various Government orders and Circulars are issued in the State.
4. Recording of vital events including strengthening of civil registration of births and deaths		up to 2% of MFP		

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
(incentive up to 2% of MFP).				
4.1 A strategy paper identifying reasons and the road map for increasing registration	By October 2013	Up to 1% of MFP	Strategy document and policy statement.	Karnataka State has implemented MCTS for registration of Mother and child to cater Health services. MCTS registration of Mother and child is done at the SC level, PHC level, CHC/TLH/DH/DLH. It is planned to issue Birth certificate through MCTS portal in Karnataka.
4.2 Death reports with cause of death (especially any under 5 children or any woman in 15 to 49 age group) shared with district health team on monthly basis.	By November 2013	Up to 1% of MFP	Death reports received at district level-verified in sample of districts.	Death reports with cause of death for infants, pregnant woman and all general deaths is available HMIS web portal. Maternal and Infant Death auditing is done at facility level and community level. DC will conduct Maternal death auditing every month.
4.3 HMIS data consistent with the births and deaths reported in CRS	By November 2013		HMIS report	HMIS report will have all the details of Birth & Deaths reported, which is available in the HMIS web portal.
5. Creation of a public health cadre (by states which do not have it already) (incentive upto 5% of MFP)		up to 5% of MFP		
5.1 Stated policy and road map (Policy & road	Up to 2% of MFP	State report	Five members committee was

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
including career path on creation of a public health cadre)	map in place by October, 2013		(copy of policy); website posting by October, 2013	constituted under the chairmanship of Dr. P.M. Halagi, former director, H&FW Services, vide G.O. No: HFW/KHSDRP/OD/PHD/16/10-11 Bangalore dated: 9-08-2010 The committee has already submitted the final report to Government for formation of Public Health Cadre in the Department of Health & Family Welfare Services.
5.2 Notification for creation of public health cadre	Government order in place.	Up to 3% of MFP	Website posting / state report	After reviewing the recommendation of the committee report, the Government order will be issued.
6. Policy and systems to provide free generic medicines to all in public health facilities(incentive upto 5% of MFP)		Up to 5% of MFP		
6.1 Clear policy articulation of free generic medicines to all in public health facilities	By October 2013		Website posting / state report	In all the Public Health facilities of Karnataka, free medicines are supplied both for In patients and out patients who attend the Hospital. Government of Karnataka has to taken steps to open 177 Generic medicines stores in all the Talukas for providing medicines at the rate of 50% less of MRP to the general public. G O has been issued wide G O

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
				No: ಆಕುಕ 68 ಹೆಚ್‌ಪಿಸಿ 2013, ಬೆಂಗಳೂರು ದಿನಾಂಕ: 31ನೇ ಆಗಸ್ಟ್, 2013.
6.2 EDLs finalised and drug formulary published and made available in all public health facilities, Overall procurement and logistics strategy in place. Detailed design and plan for rate contracting, regular stock up dates, indent management, warehousing, promotion of rational drug use, contingency funds with devolution of financial powers etc. in place.	By November 2013		Notification/ Publication/ Web posting	Essential drug list & drug formulary is available and steps are taken to revise the essential drug list for all health facilities and shortly GO will be issued for revised EDL. Detailed design plan for e-procurement of drugs & pharmaceuticals is available. Karnataka has established Drug Logistics Warehouse Society, which maintains regular stock updates, indent managements and procurement of drugs & equipments. Clear-cut guidelines are issued with delegation of financial powers to all the Administrative Medical Officers for procurement of drugs and other items at local levels. GO is available in the Website(Finance Department)
			State report/ strategy document	Karnataka is the first state to implement generic drug stores which provides medicines to the patients directly from the manufacturers. The stores would also offer 50% discount of MRP for branded drugs, surgical,

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
				essential drugs and orthopaedic implants.
6.3 Free drug availability	By November 2013		End user survey	In all the public Health facilities free drugs are available both for impatent and out patients.
7. Timely roll out of RBSK		upto 5% of RCH		
7.1 RBSK roll –out plan in line GoI guidelines in place	By October 2013		Website posting	RBSK roll –out plan as per GoI guidelines is in place and will be uploaded in the web site.
7.2 RBSK teams recruited and trained	By October 2013		Training initiated. States to report on % staff trained against planned	2 RBSK team for 176 talukas are recruited. TOT training is planned from 16 th to 20 th Feb.2014 for RBSK. Detailed training plan is already prepared for all the 30 districts and will be rolled-out as planned.
7.3 Children (including children in anganwadis) screened	By September 2013 At least 10 % , By February 2014 70% of school children and		Reports on screening to be made available on website	All the children for schools and Anganawadies are screened and month wise report from August to December 2013 is already submitted to GOI.

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
	all AWC at least once			
7.4 Empanelment of public and private secondary and tertiary facilities for referral	By October 2013		List of empanelled facilities to be available on website Report on number of children referred.	Empanelled Yeshaswini network hospital list both for public and private is available on the website. Totally 1151 cases are referred for surgery and operated in the Yeshaswini network hospitals.
8. Adopting Clinical Establishment Act 2010 as per State's/UT's requirement, to regulate the quality and cost of health care in different public and private health facilities		up to 5% of MFP		
8.1 Adoption of Clinical Establishment Act 2010 or similar Act	By November 2013		Declaration by the State, web-site posting	KPME Act 2009 - The Karnataka private medical establishment act has come into force for registering all the private medical establishments with the purpose of bringing in quality, uniformity & standard in care provided

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
				by them. Details of the KPME Act is available in the website.
8.2 Rules and regulations framed for Clinical Establishment Act 2010	By December 2013		Rules & regulations posted on the website	Rules and regulation for KPME Act 2009 is available on the website.
8.3 Institutional /regulatory framework set-up	By January, 2013		Copy of GO to be sent to GoI and posted on website	Available in the website.
8.4 Capacity building of programme management staff/others involved in implementation of Clinical Establishment Act underway	By January , 2013		% training completed	All the officers involved in the implementation of KPME Act 2009 are trained.
9. Increase in State annual health budget		Up to 5% of MFP		
9.1 More than 10% increase in State annual health budget as compared to the previous year	By November 2013		State budget and intimation letter to GoI from State	
10. Implementation of nurse practitioner model		Up to 5% of RCH base flexipool		
A strategy paper /road map for implementing nurse practitioner	By October 2013		Strategy paper to be shared	In Karnataka State modified CPHN course known as "Certificate course in

Conditionalities and incentives	Progress by the State	% incentive/disincentive recommended	Method of verification	State Remarks
model			/uploaded on website	public health nursing” is started in the year 2011-12. This course is 18months duration and first batch is completed in September 2013 and 2 nd batch is started from April 2013. The eligible candidates for this course are senior Health Assistant female, selection is on the basis of seniority cum merit.
Action Plan with time (State to train PHNs/SNs as nurse practitioners and post them in HPDs/peripheral facilities with appropriate incentives. System in place for mentoring and hand –holding)	By November		Action Plan shared/uploaded on website	
Posting of already trained nurse practitioners in HPDs/peripheral facilities with appropriate incentives	By November 2013		List of nurse practitioners and their posting to be uploaded (applicable to the states who have trained nurse practitioners)	

New Health Schemes Implemented in Karnataka for the year 2013-14 from state funds

- 1) **Rajiv Arogya Bhagya:-**A new Comprehensive Health Assurance Scheme based on 10% contribution from the APL Family has been formulated so that tertiary care is available to such people. Scheme aims to cover 1.1 crore population. Karnataka will be the first state which will have Universal Health Coverage for tertiary care in the country.
- 2) **Suchi Programme (Menstrual Hygiene):-** To promote menstrual hygiene among adolescent girls 13 packets of sanitary napkins containing 10 pads in each packet per year will be provided to 32.50 lakh adolescent girls free of cost.
- 3) **Establishment of Generic Drug stores at Block level:-** Generic Drugs are 40 to 50% cheaper than branded ones. To reduce out-of-pocket expenditure of the people State Government is opening Generic Drug Stores in all Talukas.
- 4) **Matching grants for ASHA: -** Karnataka is providing Matching incentives to ASHAs equivalent to the incentive paid by GOI to encourage them to perform better.
- 5) **Establishment of Dialysis centers at one Taluka Hospital per District:-** There is a huge demand for dialysis facilities. It is proposed to establish Dialysis centre for one Taluk Hospital per Districts in addition to already existing Dialysis Centres in all District Hospitals.
- 6) Establishment of Residential Care centers Mentally ill patients

New Health Schemes proposed for the year 2014-15 from state funds

- 1) **Strengthening of State food labs:-** To provide proper infrastructure for effective implementation of food safety and standard Act 2006. Rs. 500 Lakhs provision is made.
- 2) **Free treatment to road accident victims: -** Under "MukhyamanthrigalaSanthwanaYojane" compensation amount of Rs. 25000/- will be given through SuvarnaArogyaSuraksha Trust, to road accident victims admitted to identify hospitals within the "Golden Hour".
- 3) **Relaxation of Prasooti Araike& Madilu programme in HPD to extend the benefit to all beneficiaries:-** By relaxing the existing norms of two child limit and minimum age restriction of 19 years 'Prasuti Araike and Madilu Kit programme' will be extended to all the beneficiaries, in Bidar, Gulbarga, Koppal, Raichur, Yadgiri, Bellary, Bijapur, Bagalkot, Gadag and Chamarajanagar. Rs. 52 crore is provided for this programme in 2014-15
- 4) **Free Treatment facilities to identified diseases:-**In recent times, rare diseases such as Haemophilia, Thalassamia, Sick-cell Anaemia and Primary Immuno Deficiency are reported. A Special Unit will be set up in Indira Gandhi Institute of Child Health, Bangalore on experimental basis to provide medicines and treatment to patients suffering from these diseases.
- 5) **A new programme "AaspathreNairmalya"** will be launched to encourage cleanliness of Government Hospitals.

- 6) **Oral Health policy announced:** - It is proposed to provide free dentures to senior citizens above 60 years belonging to BPL Category. Rs. 2 crore is provided for this purpose.

New Government Medical Colleges in Karnataka

- Government of Karnataka is starting 6 new Government Medical colleges for the year 2014-15 in the following Districts :- Gulbarga, Koppal, Chamarajanagar, Karwar,(UK) Kodagu (Madikeri) and Gadag
- Government of Karnataka is proposed 6 more new Government Medical colleges which is proposed in the budget 2014-15 in the following Districts: Tumkur, Chitradurga, Chikkaballapur, Bagalkot, Haveri & Yadgir.

Community Participation

The NRHM was launched on the 12th April 2005 with the goal of improving the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, Women & Children. In order to ensure that the services reach those for whom they are meant the NRHM proposes an intensive accountability frame work that includes community based monitoring as one of the key interventions.

The accountability frame work proposes includes:

- Internal monitoring
- Periodic surveys
- Studies and community based monitoring

Community monitoring is an important aspect of promoting community led actions in the field of health. It empowers the community member, community based organizations, local committees and PRIs to systematically provide feedback on how the health system is performing.

Objective:-

The main objective of community based monitoring is to improve accessibility of quality health care services to the people residing in rural areas, poor and vulnerable groups.

Strategies:-

- Involvement of Women systematically at community level
- Establishment of accountability framework mechanism
- Involvement of VHSNC and ARS
- Social audit and communitisation efforts at PRI level
- Utilization of VHNDs as a platform for assured services

Process of community monitoring:-

It involves planning, activating, motivating, capacity building and allowing community and its representatives to directly give feedback about the functioning of public health services, including giving inputs for improved planning of the same.

The community and community based organizations will monitor demand/need, coverage, access, quality, effectiveness, behavior and presence of health care personal at the service points, possible denial of care negligence.

The monitoring process will include:

- 4) Outreach services
- 5) Public health facilities
- 6) Referral systems

The entire process of community monitoring is implemented as a partnership between the health department and civil society organizations. This process will supervise at state level and district level and also at national level.

In Karnataka various activities are planned for community participation at various levels:-

- VHSNCs and PRIs are involved in the preparation of village health plans and district health plans.
- Community health day is celebrated in all the health facility throughout the state where social auditing of the health facility is done by the community members.
- Various committees are formulated at State level, district level and facility level for community participation.
- Orientation trainings are being conducted for VHSNC, ARS and other NGO partners
- Periodic community monitoring at village, PHC, Taluk & District levels
- Fixed day village health & nutrition days are conducted in all the villages, which is a platform for assured and predictable package of outreach services. In Karnataka totally 430421 meetings are conducted as on December 2013.

Community participation at various levels in Karnataka:-

- **At village level:** VHSNCs will carry out community planning and monitoring and they will prepare village health plan and village report card
- **At PHC level:** ARS are constituted at facility level, these committees will review the performance and plan for the development of the facility. They will prepare PHC plan
- **At Taluk level:** Taluk community planning and monitoring community is formed at taluk level this committee will carry out community planning and monitoring at taluk level.
- **At District level:** District community planning and monitoring community is formed at District level this committee will carry out community planning and monitoring at District level.
- **At State level:** State community planning and monitoring community are formed at State level this committee will carry out community planning and monitoring at State level. This committee will serve as a subcommittee to the State health mission.

The Government of Karnataka has issued various guidelines and GOs regarding formation of community planning and monitoring committee.

RMNCH+A: MH, CH, Immunization, FP, AH

A.1 MATERNAL HEALTH

Introduction

Maternal health is focused around the world and nationally under the Millennium Development Goals (MDG-5) and 12th Five Year Plan respectively. As Dr. MamoudFathalla, President of the International Federation of Gynecology and Obstetrics (FIGO), World Congress mentions “*Women are not dying because of a disease we cannot treat, they are dying because societies have yet to make the decision that their lives are worth saving.*” Despite our efforts to reduce the maternal mortality the data reveals that 56000 mothers are dying in India which accounts to 20% of the maternal deaths around the world. Karnataka reported 816 maternal deaths during the year 2012-13. Hence with this view, we are focusing on the RMNCH+A strategies in the PIP 2014-17 as per the guidelines of the MoHFW, GoI, which will help us provide the comprehensive services in Reproductive, Maternal, Newborn, Child Health and Adolescents.

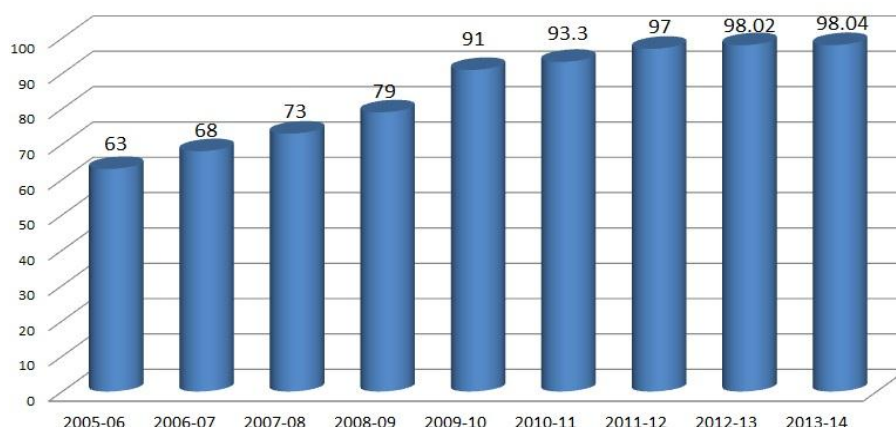
As per the MDG-5 and 12th FYP, the goal set for the maternal Mortality Ratio (MMR) is 100 per 1 lakh live births for India and Karnataka. As per the latest SRS data (2010-2012), the maternal mortality rate for Karnataka is 144 per lakh live births. The state has taken up several initiatives such as adopting RMNCH+A strategies, creation of MCH wings, regular review of maternal deaths, schemes likes JSSK, JSY, Madilu Kits, Prastuti Araiike, ThayiBhagya, ThayiBhagya plus and NaguMagu (Drop back facility).

Situational analysis:

Maternal Health Indicators: Karnataka (source DLHS, CES 2009 and HMIS)

Sl. No.	Indicator	DLHS-3 2007-08	CES 2009	HMIS 2012-13	HMIS 2013-14 (up to Nov)
1	Registration within 12 weeks	71.8	NA	62.9%	66.5%
2	3 Antenatal check ups	81.6%	91.3%	100.4%	92.54%
3	Consumption of IFA for 90 days	40.7%	NA	170.3	106.1
4	Safe deliveries	71.5%	88.4%	-	-
5	Institutional delivery	65.1%	86.4%	98.02	98.08
6	Home delivery	34.1%	NA	1.39	1.58
7	Post natal care within 2weeks of delivery	69.2%	NA	83.5	88.8

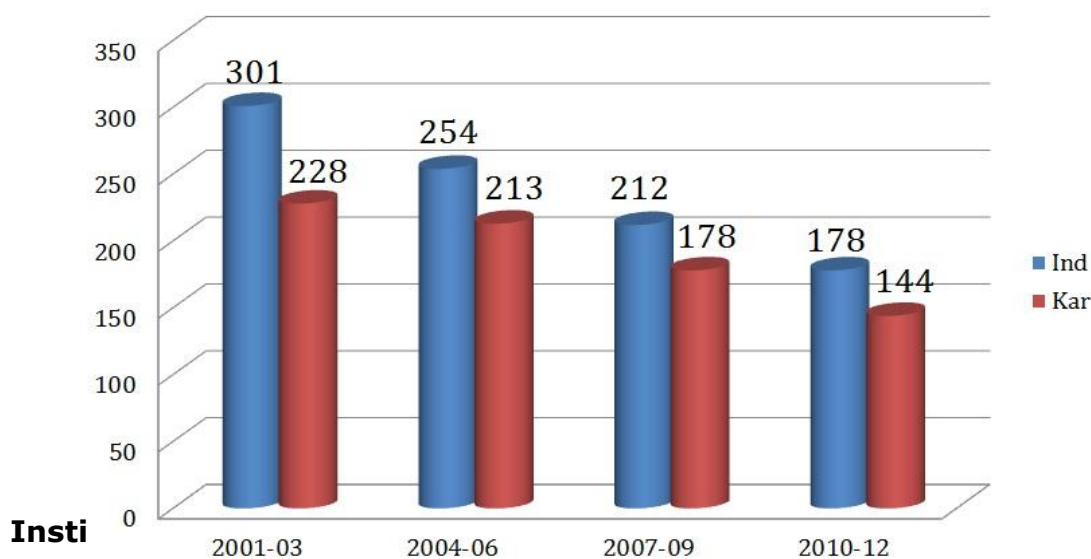
Improvement in institutional deliveries over the years (As per HMIS data)



Comparison of institution deliveries

Comparison of Institutional deliveries between the public and private facilities (last 3 years)

Comparison of Maternal Mortality Ratio of India and Karnataka



- Current MMR(India)- 178
- Karnataka MMR- 144 (SRS-2012)
- Compound Annual Rate of decline has been 6.8%(2010-12) vis-à-vis 5.8% in (2007-09)
- To achieve Planning Commission Targets, we need to achieve more than 9% decline.

Goals for maternal health of Karnataka:

The following goals envisaged for maternal health of Karnataka is to see our women go through pregnancy, childbirth and the outcome of pregnancy safely in terms of maternal and infant survival, the outcome of which is reduction of MMR & IMR:

The main objective is to reduce the MMR to less than 100 per 1 lakh live births by 2017 (NHM and 12th plan goal).

Projection of MMR for NHM:

Sl. No.	Indicator	Base line SRS data (2010-12)	2013-14	2014-15	2015-16	2016-17
1	Maternal mortality ratio	144	130	115	100	<100

Outcome indicators for maternal health (HMIS data):

Sl. No.	Indicator	2012-13	2013-14 (up to Nov)	2014-15	2015-16	2016-17
1	Registration within 12 weeks of pregnancy	87.09	87.09	92	95	97
2	3 Antenatal check ups	92.54	92.54	95	97	99
3	% of Pregnant women received TT2 & booster	91.13	87.57	90	95	100
4	Institutional delivery	98.02	98.08	99	99.5	99.5
5	Home delivery	1.98	1.92	1	0.5	0.5
6	% Newborns breast fed within 1 hour of birth to Total live birth	88.9	93.2	100	100	100
7	% of PW received PNC check up within 48 hours	75.30	79.4	82	85	90
8	% of PW received PNC check up between 48 hrs and 14 days	83.53	89.4	92	95	98
9	Proportion of Pregnant woman who are not severely Anaemic (Hb<7) 100- Severe Anaemia (Hb<7)	95.80	95.3	96	96	97

Strategies:

- Functionalization of delivery points.
- Operationalization of FRUs & 24x7 PHCs.
- Effective implementation of entitlement schemes-JSY, JSSK, Madilu, Prasoothi Araiike, Thayi bhagya & Thayi bhagya plus.
- Assured referral services & drop back facilities.
- Tracking of severe anaemic and high risk pregnancy.
- Quality Ante-natal, Intra-natal & Post-natal care.
- Establishment of MCH wings in high delivery load hospitals.
- Quality safe abortion services.
- Maternal Death review both at facility and community level
- Monitoring and effective supervision.
- Prevention and management of RTIs/STIs.
- Supplementation of Iron and folic acid for pregnant women and lactating mothers and women in reproductive age (as per National Iron Plus Initiative)

Key Activities proposed:

1. Enhancing & strengthening of Delivery Points:

Comprehensive services for maternal and child health, Family planning, immunization and ARSH will be ensured in these delivery points. These points will be strengthened in terms of infrastructure, HR, training, equipment's etc, so that full complements of RCH services are provided. Priority will be given for the capacity building of the HR for different skills of service providers at these delivery points.

As per the guidelines issued by GoI, on the basis of the deliveries conducted (average of April-13 to February-13 deliveries), 889 facilities are identified as delivery points of the state. In the present year it is proposed to increase the DPs to 1000.

Sl. No.	Type of Facility	No. of DPs (existing)	No. DPs proposed	Total no. Of DPs
1	SC	57	13	70
2	PHC	60	15	75
3	24*7	462	38	520
4	CHC (including FRUs)	135	15	150
5	TLH	136	10	146
6	DLH	9	0	9
7	DH	20	0	20
8	MC	10	0	10
Total		889	91	1000

a. Functionalization of 24x7 PHCs:

Each 24x7 PHC is providing ANC services, 24-hour delivery services both normal and assisted, Essential Newborn Care, referral for emergencies, routine immunization, services for children and pregnant women, intra natal, post-natal care, early and safe abortion services (including MVA), Family welfare services, Prevention and management of RTIs/STIs and Essential laboratory services.

Present Scenario:

Year	Functioning 24*7 PHC	Remarks
2010-11	988	-
2011-12	1001	-
2012-13	1018	-
2013-14* * Upto Feb-13	1014	Four 24 x7 PHCs are upgraded as CHCs. Hence the numbers are reduced.

Primary Health Centers are the cornerstone of rural health services. It is the first port of call in rural areas to seek the primary, preventive and curative health care services. There are 2350 PHCs in Karnataka, out of which 1014 PHCs are functioning has 24*7 PHCs in the current year. This year it is proposed to operationalise another 22 PHCs as 24*7 PHCs (Goal:1050 to be made functional 24*7 PHCs).

To achieve this following activities are proposed.

Hiring of contractual Medical Officers:

- For round the clock services at the PHCs it is planned to have one MBBS doctor at each PHC. In case MBBS personnel are not available AYUSH doctors are appointed in such PHCs.
- Services of contractual MBBS Doctors against vacancy in 24x7 PHCs are continued.
- It is proposed to provide one more additional contractual MBBS Doctor to 24x7 PHCs which are conducting more than 30 deliveries per month.

Hiring of contractual staff nurses

- 3 staff nurses to render round the clock services.

Hiring of Night assistant (female):

- A night assistant to staff nurse for every 24x7 PHCs is proposed. They have been identified by ARS of that facility. She has to stay at the PHC during the night time and assist staff nurse in the labour room. The budget provision has to be made from the ARS funds.

Justification:

To provide easy accessibility and 24x7 services to the pregnant women , lactating mothers and adolescent girls, functioning of PHCs round the clock is verymuch essential. Hence, it is necessary to continue this activity.

Deliverables:

24X7, MCH services, emergency obstetric care, Essential Newborn Care, referral for emergencies, routine immunization and implementation of al health programmes.

Funding proposed:

Sl. No.	Component	No. of units	Unit cost	Amount	FMR. Code	Remarks
1	HR					Funding proposed under HR A.8
	Medical officer					
	Addl. Medical officer (more than 30 deliveries)					
	Staff nurse					
	Lab technician					

1. Operationalising of First Referral Units (FRU):

First Referral Units are secondary/tertiary level hospitals where C-sections are conducted and where blood storage units/blood banks are established. The state has set a target of functionalizing 192 hospitals as FRUs. FRUs includes CHCs, TLHs, DHs, District level hospitals & Medical college hospitals. As of now (December-2013) 139 FRUs are functioning.

Year	FRUs
2010-11	151
2011-12	167
2012-13	166
2013-14*	139

(*upto Dec-13)

Functionalizing of FRUs is still a major issue because of the shortage of specialists and functional blood storage units / centres. To overcome this difficulty the following activities are undertaken.

- **Hiring of specialists:** Gynecologists, Anesthesiologist and Pediatrician.
- **Multi-skill training of MBBS doctors:** Regular in service MBBS doctors trained in Anesthesia and obstetrics skills.
- **LSAS:** This is imparted to enable the MBBS doctors working in the districts to administer anesthesia for the emergency obstetrics cases in the absence of the qualified Anesthetist at FRUs.

- **EmOC:** This is to enable the MBBS doctors working in the FRUs to perform LSCS and other emergency procedure for emergency obstetrics cases in the absence of the qualified Obstetricians at FRUs.

Incentives for EmOC/LSAS trained doctors:

- To encourage these trained doctors, at present an incentive of Rs.1000/- per case is being given. It is now proposed to enhance it to Rs.1500/- per case subject to a maximum of Rs.15000/- per month for performing C-Section in the FRUs.

Incentives for regular Specialists doctors in HPD:

To make the FRUs functional in the high focused districts the following proposal is made.

1. To retain the regular specialists who are working in the FRUs of high focused districts, difference of amount between the salary that they are drawing and the amount approved for contract specialists may be given to the regular specialist(permanent Govt. Employee)and this amount may be met out of NHM funds.
 2. **To motivate the regular specialists (permanent Govt. Employee) from non-high focused districts to work in high focused districts, they may be paid the difference between the salary that they are drawing and the amount approved for contract specialists and this difference amount may be met out of NHM funds to encourage them to work in High focused districts.**
- **Hiring of Contractual MBBS doctors:**
 - One additional MBBS doctor is being hired in high performing FRUs, which has an average of more than 75 deliveries per month.

Achievements:

- No. of Specialists hired: 74 working against 100 approved posts.
- MOs: 70 against 80 approved posts.
- Rs. 12.98 lakhs is paid as incentive to EmOC& LSAS trained Doctors.
- Staff Nurses:3464 against 4323 approved posts (remaining for child health).
- Lab-technicians: 129 against 149 approved posts.

Functional Blood Storage Units:

Sl. No	Name of the District	Name of the FRU	Type of Facility
1	Bagalkote (1)	District Hospital	FRU
2	Bidar (4)	G H Basavkalyan	FRU
3	Bidar	G H Humnabad	FRU
4	Bidar	G H Bhalki	FRU
5	Bidar	G H Aurad	FRU
6	Bellary (6)	Sandur	FRU
7	Bellary	Hadagali	FRU
8	Bellary	Kudligi	FRU
9	Bellary	Sirguppa	FRU
10	Bellary	Hospet	FRU
11	Bellary	H.B.Halli	FRU
12	Mandya (3)	Maddur	FRU
13	Mandya	Nagamangala	FRU
14	Mandya	K.R. Pete	FRU
15	Shimoga (6)	Shikaripura	FRU
16	Shimoga	Bhadravathi	FRU
17	Shimoga	Sagara	FRU
18	Shimoga	Thirthahalli	FRU
19	Shimoga	Hosanagara	FRU
20	Shimoga	Soraba	FRU
21	Hassan (6)	Arkalgud	FRU
22	Hassan	Arsikere	FRU
23	Hassan	Belur	FRU
24	Hassan	Channarayapatna	FRU
25	Hassan	Holenarasipura	FRU
26	Hassan	Sakleshpura	FRU
27	Bagnalore Urban (8)	Jaga Jeevan Ram Nagar, BBMP	Referral Hospital
28	Bagnalore Urban	Halsuru, BBMP	Referral Hospital
29	Bagnalore Urban	Siddaiah Road, BBMP	Referral Hospital,
30	Bagnalore Urban	Banashankari, BBMP	Referral Hospital,
31	Bagnalore Urban	Sirampura, BBMP	Referral Hospital,
32	Bagnalore Urban	Hosahalli, West of Cord Road, BBMP	Referral Hospital,
33	Bagnalore Urban	GH-Yelahanka	FRU
34	Bagnalore Urban	GH-K.R.Puram	FRU
35	Dharwad (1)	District Hospital	FRU
36	Yadgir (1)	FRU, Yadgir	FRU
37	Kolar (5)	G.H.Bangarpet	FRU
38	Kolar	G.H.Malur	FRU
39	Kolar	G.H.Mulbagal	FRU

40	Kolar	G.H.Srinivaspur	FRU
41	Kolar	SNR District Hospital	FRU
42	Chitradurga (3)	Hiriyur	FRU
43	Chitradurga	Holalkere	FRU
44	Chitradurga	District Hospital	FRU
45	Ramnagaram (2)	District Hospital	FRU
46	Ramnagaram	GH, Channapatna	FRU
47	Mysore	GENARAL HOSPITAL, K.R.NAGARA	FRU
48	Bangalore Rural (2)	GH Doddaballapura	FRU
49	Bangalore Rural	GH Nelamangala	FRU
50	Koppal (6)	Koppal	FRU
51	Koppal	Hiresindogi	FRU
52	Koppal	Gangavathi	FRU
53	Koppal	Karatagi	FRU
54	Koppal	Kustagi	FRU
55	Koppal	Kukanoor	FRU
56	Haveri (4)	FRU Hanagal	FRU
57	Haveri	FRU Akkialur	FRU
58	Haveri	District Hospital	FRU
59	Haveri	FRU Ranebennur	FRU
60	Chikkaballapur (5)	District Hospital, Chikballapur	FRU
61	Chikkaballapur	General Hospital, Chintamani	FRU
62	Chikkaballapur	General Hospital, Bagepalli	FRU
63	Chikkaballapur	General Hospital, Gowribindnur	FRU
64	Chikkaballapur	General Hospital , Sidalghatta	FRU
65	Dakshina Kannada (3)	Taluk Hospital sullia	FRU
66	Dakshina Kannada	District Hospital	FRU
67	Dakshina Kannada	Taluk Hospital Belthangady	FRU
68	Kodagu (3)	GH Virajpet	FRU
69	Kodagu	District Hospital	FRU
70	Kodagu	Kushalnagar	FRU
71	Udupi (3)	Taluk Hospital Kundapura	FRU
72	Udupi	Taluk Hospital Karkala	FRU
73	Udupi	District Hospital	FRU
74	Belgaum (11)	GH Hukkeri	FRU
75	Belgaum	CHC Sankeshwar	FRU
76	Belgaum	Soudatti	FRU
77	Belgaum	General Hospital Chikodi	FRU
78	Belgaum	CHC Nipani	CHC
79	Belgaum	GH Athani	FRU
80	Belgaum	G H GOKAK	FRU
81	Belgaum	GH Rayabag	FRU
82	Belgaum	GH Khanapur	FRU
83	Belgaum	G.H RAMDURG	FRU

84	Belgaum	G.H BAILHONGAL	FRU
85	Uttara Kannada (4)	G.H Bhatkal	FRU
86	Uttara Kannada	G.H Ankola	Non-FRU
87	Uttara Kannada	District Hospital	FRU
88	Uttara Kannada	G.H Mundgod	FRU
89	Chikkamagalur (2)	GH Tarikere	FRU
90	Chikkamagalur	District Hospital	FRU
91	Gadag (2)	District Hospital	FRU
92	Gadag	FRU Laxmeshwar	FRU
93	Davangere (2)	Jagalur	FRU
94	Davangere	Women and Children Hospital, Davangere	FRU
95	Tumkur (8)	GH, Kungul	FRU
96	Tumkur	GH, Sira	FRU
97	Tumkur	GH, Tiptur	FRU
98	Tumkur	GH, Pavagada	FRU
99	Tumkur	GH, Madhugiri	FRU
100	Tumkur	GH, C.N.Halli	FRU
101	Tumkur	GH, Turuvekere	FRU
102	Tumkur	District Hospital	FRU
103	Bijapur (2)	District Hospital	FRU
104	Bijapur	Indi	FRU
105	Gulbarga (7)	SEDAM	FRU
106	Gulbarga	CHITTAPUR	FRU
107	Gulbarga	CHINCHOLI	FRU
108	Gulbarga	JEWARGI	FRU
109	Gulbarga	AFZALPUR	FRU
110	Gulbarga	ALAND	FRU
111	Gulbarga	District Hospital	FRU
112	Raichur (5)	TLH Sindhanur	FRU
113	Raichur	TLH Lingasugur	FRU
114	Raichur	TLH Deodurga	FRU
115	Raichur	TLH Manvi	FRU
116	Raichur	CHC Mudgal	FRU
117	Chamarajnagar (4)	District Hospital	FRU
118	Chamarajnagar	SDH, Kollegala	FRU
119	Chamarajnagar	TH, Yelandur	FRU
120	Chamarajnagar	CHC kabbahally	FRU

Justification:

Fully operational FRUs will go a long way in giving the population quality maternal health services and thus will contribute in reduction of MMR

Deliverables:

FRUs by giving timely and prompt treatment, have brought down the number of referral outs. complications in the transit is avoided to a large extent and so pregnant women are benefitted immensely.

Funding proposed:

Sl. No.	Component	No. of units	Unit cost	Amount	FMR. Code	Remakrs
1	HR	Proposed under HR A.8.1.3				
	Specialists					
	OBG					
	Anae					
	Pead.					
	EmOC& LSAS Trained Doctors	2400	1500	36.00	A.8.1.6	Expected to perform 2400 cases calculated @ of 1500/- per case upto maximum 10 cases per month.
	Medical officer more than 70 deliveries	Proposed under HR A.8.1.5.				
	Addl. Medical officer more than 75 deliveries in MCH wing					
	Staff nurse					
	Addl. Staff nurse more than 75 deliveries in MCH wing					
	Procurement of equipment's					
	Solar hybrid generator	128		359		For 24x7 PHCs of High Priority districts and high case load in the CHCs / FRUs
	Consumables for Blood Storage Units	198	0.25	49.50	B.16.1 .1.1	
	MVA / EVA for safe abortion services	1500	0.01200	18.00	B.16.1 .1.2	PHC/CHC/TLH/DH
	Obstetric drapes	100000	0.000300	300.00	B.16.1 .1.3.1	
	Drugs for safe abortion	20000	0.000250	50.00		
	Parental iron (Inj. Iron sucrose)	50000	0.0004	200.00		
	Incentives to the regular specialists (permanent Govt. Employee) for OBG, Pead. And Anesthetist for working in the 8 HPD	30	0.30	90.00		The contractual specialists are being paid Rs. 1.00 lakh per month in HPDs. Regualr specialis may

						not get this amount as their regular salary. Hence an incentive of difference amount for regular (permanent Govt. Employee) is proposed to retain them in FRUs of HPD.
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**Activity: More, Most Difficult and Tribal area allowance:
This activity is a continued activity from 2006.**

Health facilities located in hard to reach areas and areas with inadequate facilities, which are not conducive for the staff to reside, have been identified by the GoI as most and more difficult areas. Communities of such identified areas are to be provided with equitable health services as in other areas. Keeping in this mind, the state proposes to encourage staff to work in PHCs located at such areas. These hard to reach area PHCs have both regular and contractual staff. To retain the staff in position and to encourage contractual staff to take up jobs, at such facilities, an allowance is proposed for each cadre. The incentives are performance based and paid on the basis of their headquarters stay.

The incentives are as follows:

Personnel	Most difficult	More difficult
Doctor	Rs 8000 pm (fixed) Rs 2,000 pm as additional (performance based)	Rs. 2000 pm
Staff nurse	Rs 2500 pm (fixed) Rs 1000 pm as additional (performance based)	Rs 1750 pm
BHEO	Rs 750pm	Rs 500pm
Ophthalmic Assistant	Rs 750pm	Rs 500 pm
LHV	Rs 750pm	Rs 500 pm
Sr. Health Inspector	Rs 750pm	Rs 500 pm
ANM	Rs 750pm	Rs 500 pm
Lab Technicians	Rs 750pm	Rs 500 pm
Male Health workers	Rs 750pm	Rs 500 pm
Pharmacist	Rs 750pm	Rs 500 pm
Group 'D'	Rs 750pm	Rs 500 pm

District wise no. of PHCs covered under most and more difficult areas

Sl. No	Districts	More Difficult	Most difficult	Total
1	Bangalore (U)	0	0	0
2	Bangalore (R)	0	0	0

3	Chikkaballapur	0	0	0
4	Davanagere	5	0	5
5	Ramanagar	1	1	2
6	Shimoga	2	3	5
7	Tumkur	0	0	0
8	Kolar	3	1	4
9	Chitradurga	11	2	13
10	Gadag	0	3	3
11	Haveri	8	0	8
12	UK	12	5	17
13	Bagalkote	7	3	10
14	Belgaum	1	0	1
15	Bijapur	0	0	0
16	Dharwad	4	0	4
17	Chikkamagalur	13	1	14
18	Chamarajanagar	3	6	9
19	D. Kannada	0	1	1
20	Hassan	7	0	7
21	Kodagu	3	3	6
22	Mysore	16	0	16
23	Mandya	3	2	5
24	Udupi	0	0	0
25	Bidar	5	5	10
26	Koppal	8	4	12
27	Raichur	10	0	10
28	Bellary	6	6	12
29	Yadgiri	5	5	10
30	Gulbarga	11	4	15
	Grand Total	144	55	199

Achievements:

Total Expenditure: 50.04 lakhs.

Justification

The areas where population is sparse and the houses are situated far apart they should be equipped with all health facilities, more so the maternal health benefits by encouraging health personnel to stay in the headquarters and so this monetary incentives are justified. Hence these incentives are given on a condition that the personnel should stay in the head quarters.

Deliverables:

The stationed health personnel will offer their services when required and timely interventions has helped in reducing mortality and morbidity.

Budget proposed for Most difficult area allowance:

Sl. No.	Designation	No. of units	Unit cost (Rs.in lakhs)	Total amount (Rs.in lakhs)	FMR code.
1	Doctor	25	0.125	37.50	A.8.1.10.1
2	Staff nurse	55	0.035	23.10	A.8.1.10.1
3	BHEO	5	0.008	0.48	A.8.1.10.1
4	Ophthalmic Assistant	8	0.008	0.77	A.8.1.10.1
5	LHV	15	0.008	1.44	A.8.1.10.1
6	Sr. Health Inspector	15	0.008	1.44	A.8.1.10.1
7	ANM	55	0.008	5.28	A.8.1.10.1
8	Lab Technicians	25	0.008	2.40	A.8.1.10.1
9	Male Health workers	20	0.008	1.92	A.8.1.10.1
10	Pharmacist	25	0.008	2.40	A.8.1.10.1
11	Group 'D'	25	0.008	2.40	A.8.1.10.1

Budget proposed for More difficult area allowance:

Sl. No.	Designation	No. of units	Unit cost (Rs.in lakhs)	Total amount (Rs.in lakhs)	FMR code.
1	Doctor	70	0.025	21.00	A.8.1.10.1
2	Staff nurse	100	0.018	21.60	A.8.1.10.1
3	BHEO	15	0.005	0.90	A.8.1.10.1
4	Ophthalmic Assistant	8	0.005	0.48	A.8.1.10.1
5	LHV	25	0.005	1.50	A.8.1.10.1
6	Sr. Health Inspector	10	0.005	0.60	A.8.1.10.1
7	ANM	80	0.005	4.80	A.8.1.10.1
8	Lab Technicians	25	0.005	1.50	A.8.1.10.1
9	Male Health workers	15	0.005	0.90	A.8.1.10.1
10	Pharmacist	20	0.005	1.20	A.8.1.10.1
11	Group 'D'	20	0.005	1.20	A.8.1.10.1

Tribal area allowance:

The tribal districts in the state are namely Mysore, Kodagu & Chamrajanagar. Some PHCs of these districts are located in forest areas, inaccessible and remote places and health staffs working in such places are given special incentives in addition to their salary.

Medical Officer – Rs.2000/- per month

Staff nurse: Rs.1000/- per month

ANM: Rs.750/- per month

Sl. No.	Name of the District	No. of Tribal area Health Centers
1	Mysore	13
2.	Chamarajanagar	15
3.	Kodagu	31
	Total	59

Achievements:

Total expenditure: Rs. 14.27 lakhs

Justification:

It is proposed to continue assistance as in the previous years to encourage Medical Officers and other health personnel working at such PHCs to provide comprehensive health care services to the underserved and unreached community.

Deliverables:

Functionalization of the most & more difficult area PHCs to cater Primary health care services to the community in the most & more difficult areas, underserved areas especially the vulnerable groups.

Budget proposed:

Sl. No.	Designation	No. of units	Unit cost(Rs.in lakhs)	Total amount
1	Medical Officer	59	0.02	14.16
2	Staff nurse	60	0.01	7.20
3	ANM	50	0.0075	4.50
	Total			25.86

Funding Proposed:

Activity	Total Cost (Rs. In Lakhs)	FMR code
More remote	30.00	A.8.1.10.1
Most remote	40.00	
Tribal allowance	26.79	
Total	96.79	

Name of the Activity: Operationalization of Sub centers

The sub centre is the 1st point of contact for the community for health care services. It is proposed to strengthen the functioning of the sub centre so as to provide quality health services for the mother and the child. The activities that are taken up in these centers is as follows.

Village Health and Sanitation Nutritional Committees (VHSNC): Brief description of function of VHSNC:

- i. In every village VHSNC are formed to undertake basic health services. They are expected to undertake household health survey, to maintain hygiene & good sanitation in the community. Every committee is given Rs.10000/- as untied fund annually to meet the expenditure incurred for health services.
- ii. The VHSNCs will track the antenatal mothers and their expected Delivery Date (EDD) will be communicated to Arogya Kavacha (108) ambulance services which in turn track the expected mother and provide free transportation services to her to deliver in the hospital. This will promote institutional deliveries.
- iii. Awareness programmes for pregnant women to promote adequate nutritional food and personal hygiene during pregnancy, prophylaxis and treatment of anemia and counselling regarding the importance of nutritious food will be addressed in these programmes.
- iv. ASHAs and AWWs are trained to organize focus group discussions on maternal deaths and create awareness regarding advantage of Institutional deliveries

b. ANM for vacant sub centers:

- i. There are 8871 sub centers in Karnataka, out of which many sub centers do not have the services of ANM.
- ii. This has contributed to the lack of service provision at the sub centers.
- iii. 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.
- iv. They will provide MCH services & detect high risk pregnancy and also participate in the Non communicable disease control programmes and also implement all other health related activities in the community.
- v. It is proposed to continue 990 ANMs from 2013-14 and add another 604 ANMs (200 in HPD and 404 in non HPDs) to vacant sub centres in the PIP 2014-15.

c. Rent for sub centers:

- i. It is proposed to give rent for the sub centers which do not have building of their own. These sub centers function at rented buildings.
- ii. It is proposed to provide rent facilities to all these sub centers. The rent facility will facilitate the stay of Junior Health Asst, Female at her place of posting, so as to provide maternal and child health services.
- iii. Rs. 1000/- pm (Rs. 12000/- p.a) is proposed for each center as rent, which has to be certified by the MO PHC.

d. Sub centers logistics:

- i. SahlisHaemoglobin Meter (untied fund).
- ii. Urine testing strips 1000 / sub centers (untied fund).

- iii. BP apparatus and weighing machines are mandatory for each sub center (untied fund).

b. It is a continued activity

c. Achievements if continued from previous years:

There are 1000 centers functioning in rented building

Justification:

To provide basic MCH services at SC level it is necessary for ANMs to stay at the headquarters. Hence it is proposed to continue this activity of provision of rent to SC.

Deliverables:

It is proposed to fill 990 ANMs in the year 2014-15 on the contractual basis to cater MCH services and other health programmes.

d. Funding Proposed:

(Rs. In Lakhs)						
Sl. No.	Particular	No of Units *	Cost per unit	Total Cost	FMR code	
1	Salary for contractual ANM	Budget under HR A.8.1				
2	Rent	1000	0.01	120.00	B.4.3	
Total				120.00		

a. Activities Proposed: Janani Suraksha Yojane

b. Name of the Activity: Janani Suraksha Yojane

Government of India initiative to provide financial assistance to all BPL SC/ST delivered mother as a wage loss compensation. BPL/SC/ST women regardless of age and number of children for delivery in government / private accredited health facilities in the High Performing States.

c. It is a continued activity

d. Achievements if continued from previous years:

Sl. No	Year	Home Delivery	Institutional Delivery		LSCS	Total
			Rural	Urban		
1	2005-06	20400	30142		-	50542
2	2006-07	93639	133778		-	227417
3	2007-08	86082	196918		-	283000
4	2008-09	107134	214047	79168	-	400349
5	2009-10	62083	296825	56957	59328	475193
6	2010-11	31748	292172	57368	64833	446121
7	2011-12	16298	298280	67,911	72305	454794
8	2012-13	9572	261516	63975	72548	407611
9	2013-14	2719	128839	35710	42328	209596

e. Justification:

women belonging to BPL/ SC/ST to a large extent are contributing to the family finances by working, when they become pregnant they are at disadvantage because of their abstinence from work and so if they are compensated by a cash incentive, it will help them temporarily to avoid hardship and combat the nutritional deficiency.

Deliverables:

1	Estimated ANC registration	13 lakhs
2	Estimated Institutional Deliveries	8.75 lakhs
3	Expected BPL & SC/ST Deliveries	6.125 lakhs
4	Estimated no. of home deliveries	10000
5	Estimated no. of Rural institutional deliveries	5.76 lakhs
6	Estimated no. of urban institutional deliveries	2.00 lakhs
7	Estimated no. of LSCS	1.00 lakhs

Funding proposed

Rs. In Lakhs					
Sl. No.	Components	No of Units	Cost per unit	Total Cost	FMR code
1	Home Deliveries	10000	500.00	50.00	A.1.3.1
2	Institutional Deliveries			0	A.1.3.2
	Rural	576000	700.00	4032.00	A.1.3.2.a
	Urban	200000	600.00	1200.00	A.1.3.2.b
	C-Section	100000	1500.00	1500.00	A.1.3.2.c
3	Administrative cost for JSY (Printing, monitoring etc.)			50.00	A.1.3.3
	Total			6832.00	

a. Activities Proposed: JananiShishuSurakshaKaryakrama**b. Name of the Activity: JananiShishuSurakshaKaryakrama**

- This programme mainly entitles all category of pregnant women (APL and BPL) delivering in public health institutions absolutely free and no out of pocket expenditure on delivery, including a caesarean section and obstetric emergencies like incomplete abortion.
- It clearly spells out that all expenses related to delivery would be borne entirely by the government and no user charges would be levied.

Entitlements under this programme are:

- Free Checkups during pregnancy.
- Free diagnostics.
- Free Lab facilities (Urine, Blood etc)
- Free delivery services including C-section
- Free Blood for needed pregnant women / delivered mother
- Free diet.

- Free Transportation (From Home to Health facility, health facility to higher facility and drop back) (i.e. 108, Janani Shuraksha Vahini & Nagu Magu)

c. It is a continued activity

d. Achievements if continued from previous years:

Year	Free Drugs & Consumables	Free Diet	Free Diagnostics	Free blood
2012-13	518184	330534	341806	11935
2013-14	313816	272680	306856	10190

e. Justification:

- 12th five year plan aims to bring all women during pregnancy and children into the institutional fold, so that delivery care services of good quality can be provided to them at the time of delivery at zero expenses for all category pregnant women (i.e. APL & BPL) who are delivering in Govt. Institutions. Hence this activity is continued.

f. Deliverables:

Total No. of deliveries conducted during 2013-14 (upto Feb-14) is as follows:

Sl. No.	Facility Type	No. of deliveries
1.	PHCs	31099
2.	24x7 PHCs	141677
3.	CHC	2526
4.	CHC-FRUs	15184
5.	TLH-FRUs	155213
6.	DHs	64657
7.	Maternity centers	19528
8.	Medical Colleges	85123

Funding Proposed for 2014-15:

Sl. No.	Component	No. of Units	Unit Cost	Amount (Rs. In Lakhs)
1	Diagnostics	400000	200	800.00
2	Drugs and Consumables (for both Normal and C-section)	500000	600	3000.00
3	Blood transfusion for pregnant / delivered mother	30000	500*	150.00
4	Diet for all (except dieted hospitals) (at Rs.75/- for normal for 3 days & for 7 days for C section cases)	400000		300.00
5	Referral Transport (@ Rs. 250/-)	60000	250	150.00
	Total			4400.00

*NBTC – KSBTC approved rates

a. Activities Proposed: Madilu (Post Natal Kit for delivered women)

b. Name of the Activity: Madilu

- To reduce the MMR and IMR and and promote institutional deliveries, Government of Karnataka had launched this program called "**Madilu**" from 2007 and this activity is a continuing activity.
- The aim of this program is to provide a Post-natal kit to the delivered mothers of BPL & SC/ST category for the first 2 live births, which contains 19 articles for the use of the mother and the new born baby like bedspreads, soaps, mosquito nets and detergents etc.
- This programme is extended for all beneficiaries (both APL & BPL) in high priority districts of Karnataka irrespective of age and parity (i.e. Bagalakote, Bidar, Bellary, Bijapur, Gadag, Gulbarga, Koppal, Raichur, Yadgiri&chamarajanagar) from 2014-15.

c. It is a continued activity

d. Achievements if continued from previous years:

Period	Physical			
	Gen	SC	ST	Total
2010-11	185374	67833	33868	287075
2011-12	225099	79713	41365	346177
2012-13	210921	78184	38437	327542
2013-14	136279	48987	24252	209518

e. Justification:

A Post-natal kit is given to the delivered mother, which contains 19 items for the use of the mother and the new born baby like bedspreads, soaps, mosquito nets and detergents etc. The kit encourages cleanliness thus reduce the incidence of sepsis both in mother and child. This will promote Institutional deliveries and hospital stay upto 48 hrs and contribute to the reduction of IMR & MMR. Hence this activity is continued.

f. Deliverables:

These kits are issued for the delivered mothers at the public health facilities viz. SCs, PHCs, CHCs, FRUs, DH, Maternity Centers and Govt. Medical Colleges.

g. Funding Proposed:

It is proposed to provide 4.00 lakhs kits for the year 2014-15 only 50% of which is budgeted under NHM.

Sl. No.	Activity	No of Units*	Cost per unit	Total Cost (Rs. In Lakhs)	FMR code
1.	Madilu	200000	2000	4000.00	B.14.3

a. Activities Proposed: Printing & Supply of Thai Card (MCP Cards) and other materials (My safe motherhood booklets, Referral slips & Case sheets for 24x7 PHCs)

Name of the Activity: Printing & Supply of Thai Card (MCP Cards) and other materials (My safe motherhood booklets, Referral slips & Case sheets for 24x7 PHCs).

- Thai card is a comprehensive Antenatal registration booklet developed in collaboration with the WCD.
- 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, immunization and growth plotting of the child.
- It also helps in recording the disbursement of the JSY/PrasuthiAraike as well as Madilu kits.
- It is proposed to provide Thai card for all the antenatal cases.

Safe motherhood booklet:

- This is a tool for empowering women to know her rights on the quality of service delivery being imparted during ANC, PNC and immunization.
- The booklet also gives knowledge and information on the different activities being undertaken during the provision of these services.
- It is proposed to give safe motherhood booklet to all the pregnant women in local language along with thai card.

It is a continued activity

Achievements if continued from previous years:

For the year 2012-13 totally 15.00 lakhs cards were printed and distributed to the district health facilities.

Justification:

- It is comprehensive antenatal card. It is used for registering pregnant woman and for necessary follow ups of Mother and Newborn. This cards given to all pregnant women along with **my safe motherhood books**. This is an important tool which tracks the service delivery to mother and child. Hence it is proposed to continue this activity.

Deliverables:

To all pregnant women of the state. It is estimated to procure 13.50 lakhs Thai cards and my safe motherhood booklets.

Funding Proposed:

Sl. No.	Activity	No of Units	Unit cost in Rs.	Total Cost in lakhs	FMR code
	Printing & Supply of Thai Card (MCP Cards) and other materials	1350000	20.00	270.00	B.10.5.1

a. Activities Proposed: Obstretic Drapes

Name of the Activity: Obstretic Drapes

- The current standard practice of postpartum blood loss assessment throughout the world is visual estimation. Visual estimation is performed by a health care

provider who looks grossly at the blood lost during the delivery process and makes a quantitative estimate. This method is highly inaccurate.

- A blood collection drape is specially designed to assist in estimating postpartum blood loss in low-resource settings.
- This collection drape has the potential to provide an objective measurement of postpartum blood loss and allows for a more accurately diagnosis of PPH than does visual assessment.
- It is observed that, the most of maternal deaths are occurred during the referrals form primary centers. Hence it is planned to procure Drapes for all 24x7 PHCs deliveries i.e. approximately 2.00 lakhs delivery.

It is a continued activity

Achievements if continued from previous years:

Justification:

In order to reduce the MMR as result of PPH which is a major preventable cause of maternal death, it is proposed to procure Obstretic drapes which quantifies the blood loss and enables early referral. Hence this activity is proposed.

Deliverables:

It is proposed to procure for all the deliveries at 24*7 PHCs. It is estimated 1.00 lakhs deliveries at 24*7 PHCs.

Funding Proposed:

Sl. No.	Activity	No of Units	Unit cost in Rs.	Total Cost in lakhs	FMR code
	Obstretic Drapes	100000	0.000300	300.00	B.16.1.1.3.3

a. Name of the Activity: Maternal Death Review

b. It is a continued activity

Maternal Death review is an important strategy to assess the quality of obstretic care, to identify the probable cause, to find the solution if any. The review provides a detailed information on various factors at facility, district, community, regional and national level that are needed to be addressed to reduce maternal deaths. Community based death review involves extensive conversation with the bereaved family which helps in bridging the gap between people and the health care personnel

Analysis of these deaths can identify the delays that contribute to maternal deaths at various levels and the information used to adopt measures to fill the gaps in service.

Steps taken by state:

We have already identified the District Nodal Officer to analyse data in the district.

Conducting workshops at divisional level for gross root level health personnel:

- This workshop will be reorientation for the staff nurses working in the PHCs from all four divisions of Karnataka by experts who will educate them regarding the early recognition of any complication and timely referral which goes a long way in getting quality services and save the life of both mother and child. It will be very helpful in imparting the knowledge to the health workers who in turn will educate people about timely seeking of treatment. The workshop also helps in educating them regarding treatment of minor complications.

It is proposed to conduct 4 division level workshops for the year 2014-15.

Achievements if continued from previous years:

One regional workshop was conducted in July-13 at Mysore.

There are 4 divisions in the state. In this regard, this year state has decided to conduct workshops to gross root level health providers i.e. Staff nurses preferably from 24/7 PHCs.

Constitution of Sub-committee for reviews: the reviewed maternal deaths reports:

The maternal deaths reviews are being done according to the protocol of both CBMDR and FBMDR. The data collected is compiled which on analysis, shows that causes of death in many cases is written as OTHERS. This needs to be looked into in depth and hence there is a requirement to constitute an expert committee. The committee consisting of professor from a medical college, a FOGSI member and RCHO of concerned will conduct the review at the place and with their expertise will be able to unearth the missing links. A more accurate cause if any can be found out which will also help us to evolve strategies.

Justification:

The re-review committee, with the expertise, will be able to come out with feasible solutions and health care personnel can formulate the strategies. Hence, this activity is proposed.

Achievement:

The execution of this programme is delayed as the written consent from the medical college professors is awaited and also a positive reply from the FOGSI member is yet to be received.

Deliverables:

A more scientific way of analysing the accurate cause of death by experts will go a long way in finding the solutions.

Funding Proposed:

						Rs. In Lakhs
Sl. No.	Activity	No of Units	Unit cost	Total Cost	FMR code	Remarks
1	Maternal Death Review Workshops	4	5.00	20.00	A.1.4	
2	Re-review committee	2 Divisions	10.00	20.00	A.1.5.1	As budgeted in previous year.
	Total			40.00		

a. Activities Proposed: MDR software roll out plan.**b. New initiative.**

IMR and MMR are the important Health indicators of a country, region, state etc. Evaluating the cases for these indicators would help formulating/modifying various health and administrative intervention. GOI has already formulated guidelines for Maternal Death Review (MDR) which takes in to account many parameters. Computing these parameters manually and analyzing at the PHC/CHC/DH and state level would not only be time consuming but also involves a considerable man power. In view of which GOI has already launched MDR software developed by AVNI Health Foundation (AVNI) on 25 November 2013.

The MDR software launched at National level needs to be adapted by the state at the HQ, District, Taluk / PHC levels, which requires training of manpower at all levels. In the beginning, technical manpower from AVNI would be available for training of state HQ/ other teams from the state as phase I and II respectively.

c. New Activity**d. Justification:**

The analysis of MMR and IMR report at various levels will be made more systematic and regular with adequate training. Hence this activity is proposed.

e. Deliverables:

Systematic analysis of causes of maternal deaths

f. Funding Proposed:**MDR SOFTWARE TRAINING – PHASE-I (15 persons x 2 days)**

Item	Amount	Number of persons	Number of days	Total Amount
Resource Person Travel	20,000.	2		40,000.00
Resource Person Local Travel	500.	2	2	2,000.00
Resource Person Stay	3,500.	2	2	14,000.00

Resource Person Honorarium	1,000.00	2	2	4,000.00
Per Diem	500.	2	2	2,000.00
Administrative charges for organization of the program				9,000.00
Refreshmensts	300.00	15	2	9,000.00
Trainig materials (Pen Pad, folder, manual)	500.00	15	2	15,000.00
Rent for Hall and LCD projector	5,000.00	0	2	10,000.00
Miscellaneous Expenses	5,000.00	0	0	5,000.00
Total				110,000.00

MDRSOFTWARE TRAINING – PHASE-I (15 persons x 3 days)

Item	Amount	Number of persons	Number of days	Total Amount
Resource Person Travel	20,000.00	1		20,000
Resource Person Local Travel	500.00	1	3	1,500
Resource Person Stay	3,500.00	1	3	10,500
Resource Person Honorarium	1,000.00	1	3	3,000
Per Diem	500.00	1	3	1,500
Administrative charges for organization of the programme				5,250
Refreshmensts	300.00	15	3	13500
Trainig materials (Pen Pad, folder, manual)	500.00	15	3	22500
Rent for Hall and LCD projector	5,000.00	0	3	15000
Mesillanious Expenses				5000
Total				97,750

New innovative activity – Procurement of endoscopic work station as a Pilot project on MTP

a. Activities Proposed: Procurement of equipment for Medical Termination of Pregnancy

b. Name of the Activity: Procurement for Medical Termination of Pregnancy

c. New Initiative

Medical Termination of pregnancy is a major service provided by the MCH wing and is one of the contributor in reducing the MMR by avoiding the death due to abortions in the hands of untrained attendants . There were 25,542 MTPs conducted in the public institutions for the year 2012-13 and 11,981 MTPs for the year 2013-14 till November 2013, 72% of the above number is MTPs done in pregnancies of below 12 weeks and 28% for pregnancies above 12weeks.

Medical Termination of pregnancy done with MVA syringes by vacuum aspiration has a possibility of retained products of conception, post abortion infertility and infection etc. It will be preferable to improve the outcome by reducing the incidence of the above sequelae if done with endoscopic visualization. The quality of procedure will be better and also can be used as both diagnostic and teaching tool.

The endoscopic cannula endoscopic work station is equipped with video endoscope and a camera helpful during the procedure, as they can be monitored throughout and also can be documented for further references.

Hence, this above work station can be taken as pilot project in a high priority district of Bijapur (Which was awarded as the best district hospital of the country) and Gadag.

d. Achievements if continued from previous years: New activity

e. Justification:

M T P s if done with the help of advanced technology will reduce the mortality and morbidity to a great extent.

f. Deliverables:

Will be taken as pilot project in two districts of Bijapur and Bagalkot

g. Funding Proposed:

					Rs. In lakhs
Sl. No.	Activity	No of Units*	Unit cost	Total Cost	FMR code
a.	Endoscopic work station	2	8.50	17.00	A.1.5.2
b.	Disposal Cannula	35	0.085	3.00	
Total				20.00	

a. Activities Proposed: Procurement of MVA syringes for safe abortion

b. It is a continued activity.

- As per the department data, abortion accounts for 1% of maternal deaths. There may be under reporting as illegal abortions and those conducted by unauthorized providers goes unreported.
- Management of unwanted pregnancy through early and safe MTPs as envisaged under the MTP act is an important component of RCH-2. It is proposed to provide Safe Abortion Services at all the 24 x 7 PHCs and FRU's and required equipment and training to service provider for the same will be provided.

Justification:

MVA syringe is a simple tool which is used in PHCs and FRUs for conducting MTPs.

h. Deliverables:

It is proposed to supply to all 24x7 PHCs and FRUs. It is estimated to supply 2800 MVA / EVA for safe abortion services.

i. Funding Proposed:

Rs. In lakhs					
Sl. No.	Activity	No of Units*	Unit cost	Total Cost	FMR code
	MVA / EVA for safe abortion services	1500	0.01200	18.00	B.16.1.1.2

a. Name of the Activity: Procurement of Inj. Iron Sucrose for Anaemic Pregnant Women.**b. It is a continued activity**

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 foetal outcome.

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 with severe anaemia.

Hence to improve the severe anaemic it is proposed to provide iron sucrose to the severe anaemic women which is able to raise the Hb to satisfactory level.

Every year around 13 lakhs ANCs are registered in the state. Out of which, approximately 7% of the pregnant women are severely anaemic. Therefore it is proposed to procure 50000 units (1 unit = 10 ampules, 5 ampules for each beneficiary) for 1,00,000 beneficiaries (No. of severe anaemic ANCs). Approximate cost per unit is Rs. 400/-.

c. Achievements:**d. Justification:**

One of the cause of high risk in pregnancy is severe anaemia. Pregnant women with severe anaemia cannot with stand minimal bleeding also, during delivery. The severely anaemic pregnant women can be treated better with inj. Iron Sucrose which brings up the Hb% faster.

e. Deliverables:

By giving Inj. Iron sucrose to severely anaemic pregnant women which constitute about 5-7% of ANCs, the general health is improved and complication during delivery is brought down to a great extent.

f. Funding Proposed:

Rs. In Lakhs					
Sl. No.	Activity	No of Units*	Cost per unit	Total Cost	FMR code
1.	Inj. Iron Sucrose	50000	0.004	200.00	B.16.2.1.3.1

a. Activities Proposed: Drugs for Safe Abortion

b. Name of the Activity: Drugs for Sage Abortion

c. It is a continued activity

Management of unwanted pregnancy through early and safe MTPs as envisaged under the MTP act, is an important component. Abortion accounts for 1% of maternal deaths (department data). There may be under reporting as illegal abortions and those conducted by unauthorized providers goes unreported.

Hence, it is proposed to provide Safe Abortion Services at all the 24x7 PHCs and FRU's and required equipment and training to service provider for the same will be provided.

d. Justification:

The studies have shown that abortions conducted by unauthorized persons may lead to many of the complications described and many in some cases death also. Hence, it is very essential to store adequate drugs for safe abortion.

e. Deliverables:

Safe abortion services are ensured for the pregnant women by which 1% of the maternal mortality that is contributed by MTPs is brought down.

f. Funding Proposed:

Rs. In Lakhs					
Sl. No.	Activity	No of Units	Cost per unit	Total Cost	FMR code
1.	Drugs for Safe Abortion	20000	0.00250	50.00	B.16.2.1.2

g. Activities Proposed: Identification of High Risk Pregnancy

h. Name of the Activity: Identification of High Risk Pregnancy

Around 15% of pregnancies are considered to be with high risk, to achieve successful maternal and foetal total outcome. The pregnant women have to be registered in the first trimester itself, should have 3+ ANC, IFA supplement / Iron sucrose injection, should required immunization at proper time and must be under expert medical supervision. So institutional delivery has been advocated with high risk pregnancies. The causes of high risk are to be recognized early & treated during pregnancy period itself to bring down the MMR.

Justification:

Maternal Death analysis has shown that the deaths are common in pregnancies with high risk and if detected early and suitable measures are implemented, most of these deaths can be prevented.

Deliverables:

ANMs are already trained to recognize the high risk pregnancies in the first trimester and incentives are given to the ANM who get the these pregnant women for ANC care, convert them to 3 ANC, institutional delivery and PNC, Rs. 250/- for each ANM is being given as a motivational incentive.

i. Funding Proposed:**Rs in Lakhs**

Sl. No.	Activity	No Units* of	Cost per unit	Total Cost	FMR code
1.	Identification of High Risk Pregnancy	50000	0.00250	125.00	A.8.1.9

a. Activities Proposed: Procurement of Equipment's under Maternal Health**b. It is a continued activity**

- i. The current status of continuous flow of electricity in the northern Karnataka is far from satisfactory. The delivery of health services in the 24x7 institutions will be affected because of this concern pregnant women will be discouraged to have an institutional delivery, if the condition continues and to promote more institutional deliveries it is imperative that we have uninterrupted power supply and build up confidence in the pregnant women. Hence, Solar hybrid Generators are essential in ensuring this power supply.

c. Justification:

To prevent intraoperative complications at FRUs and to improve foetal and maternal outcome during delivery, the hospitals are to be equipped Generator. Hence this activity is proposed.

d. Deliverables:

It is proposed to procure 100 solar generators of 3 KW for 24x7 PHCs in HPDs.

Requirement of Generators**a. Funding Proposed:**

Sl. No.	Activity	No of Units	Cost per unit	Total Cost	FMR code
1.	Equipments				
a.	Solar Hybrid Generators	100	3.00	300.00	B.16.1.1.3.2

Budget Summary Sheet:**Rs. in lakhs**

Sl. No.	Activity	FMR Code	Target	Budget Proposed
1	Janani Suraksha Yojane			
a.	Home Deliveries	A.1.3.1	10000	50.00
b.	Inst. Deliveries Rural	A.1.3.2.a	576000	4032.00
c.	Inst. Deliveries Urban	A.1.3.2.b	200000	1200.00
d.	C Section	A.1.3.2.c	100000	1500.00
e.	Administrative Cost	A.1.3.3		50.00

f.	Asha Incentive	A.1.3.4	500000	3000.00
2	Maternal Death Review (Both in Facility & Community)	A.1.4	4	20.00
3	MDR Support Team	A.1.5.2	2	20.00
4	MDR Software	A.1.5.3	2	2.08
5	Janani Shishu Suraksha Karyakrama			
a.	Drugs & Consumables	A.1.6.1	500000	3000.00
b.	Diagnostics	A.1.6.2	400000	800.00
c.	Blood	A.1.6.3	50000	150.00
d.	Diet	A.1.6.4	400000	300.00
e.	Referral Transport	A.1.6.5	60000	150.00
6	More/Most/Tribal area allowances	A.8.1.10.1	2000	96.79
7	Additional Allowances/ Incentives to M.O.s	A.8.1.6	2400	36.50
8	Incentive for Regular specialists working in FRUs of HPDs	A.8.1.10.4	100	90.00
9	Human Resources Development (Other than above) (Identification of High Risk Pregnancy)	A.8.1.9	50000	125.00
10	Sub Centre Rent and Contingencies	B.4.3	1000	120.00
11	Printing of MCP cards, safe motherhood booklets etc	B.10.7.1	1350000	270.00
12	Madilu	B 14.2	200000	4000.00
13	MVA /EVA for Safe Abortion services	B.16.1.1.2	1500	18.00
14	Solar hybrid Generator for 24 x 7 PHCs	B16.1.1.3.2	100	300.00
15	MTP Work station	B16.1.1.3.5	2	20.00
16	Drugs for Safe Abortion	B.16.2.1.2	20000	50.00
17	Consumables for Blood Storage Units	B16.1.1.1	120	36.00
18	Parental iron	B.16.2.1.3.1	50000	200.00
19	Obstratic drapes	B16.1.1.3.1	100000	300.00
	Total			10075.79

Activity Proposed: Providing of HIV Screening Test Kits

It is a continued activity since FY 2010.

Purchase of HIV screening test kits for 1014 - 24x7 PHCs, 64 non-24PHCs which are delivery points, 376 PHCs in high priority districts Gulbarga, Bagalkot, Bellary , Bidar, Bijapur, Koppal, Raichur and Belgaum which are having high prevalence rate for HIV and 46 referral hospitals in Bangalore urban district (highly populated).

Karnataka State AIDS Prevention Society has expanded the base of institutions providing ICTC services through integration with NRHM since 2010-11. Till 2013-14, HIV test kits were provided only to 24x7 PHCs. Now in 2014-15 we propose to extend the programme to other PHCs and referral hospitals with high case load.

HIV counseling and testing services are being offered to all ANCs by staff-nurses working in 24x7 PHCs (1014), 440 non-24x7 PHCs and 46 referral hospitals & Mobile Health Clinics (95). Same services are rendered by counselors and lab technicians in 86 ICTCs located in PHCs. KSAPS is also planning to train staff nurses and lab technicians of other PHCs, where there are high client loads through NACO funds.

Achievement: During 2013-14 the state had received an approval of Rs. 395.42 lakhs to procure 33000 kits @ Rs.40.00 per test. The process of completion of procurement is likely to be completed by March 2014.

Justification:

During 2013-14 around 7.8 lakh ANCs are tested for HIV in the state till November against a target of 12.9 lakhs for the year (most of which are in government facilities). This will ensure every ANC would know her HIV status before delivery. This programme if continued will help in testing the mother and child early, access services and ensure keeping the positive mothers and children alive. Hence it is planned to expand the programme for 2014-15.

Deliverables: Approximately 1500 Health Care units will be undertaking HIV screening to ante-natal cases, High Risk Groups and general population and also in the inaccessible and underserved areas.

Funding Proposed:

Unit cost: Rs 50 per test -Total Testing units 1500 (facilities) X 2 tests per day X 30 days = 90000 tests per month

90000 tests X 12 months=1080000 tests)

No of Units*	Cost per unit (in Rs.)	Total Cost (Rs. In lakhs)	FMR code
1080000	50.00	540.00	B.16.2.1.3.4

SUPPORTIVE INCENTIVES TO HIV POSITIVE PREGNANT WOMEN

Activity Proposed: Support to HIV positive pregnant women for cashless institutional deliveries, @ Rs 5500 for Normal deliveries and Rs 10,000 for Caesarian sections.

It is a continued activity since FY 2008.

KSAPS has integrated with the Department of Co-operation for implementation of National Health Insurance Scheme in Karnataka known as the Yeshaswini Scheme in 2008. This has enabled a HIV positive pregnant woman choose a Yeshaswini Network Hospital for cashless delivery services from any of 562 Yeshaswini Network hospitals (325 public and 237 private).

Details of distribution of incentives within the Govt. Yeshaswini Network Hospitals upon receipt of re-imbursements by FHPL, Bangalore & Mediassist (or) MD India Network, Bangalore - Yeshaswini Scheme, vide Circular No. DD(MCH)/106/11-12 issued by Commissioner of H&FW Services and MD, NRHM, dt. 23/08/2012				
Sl. No.	Details of Yeshaswini Incentive Recipients	Percentage of distribution of incentives/case	Amount reimbursed towards services provided	
			Normal Delivery (Rs.)	Caesarean Section (Rs.)
1	To Arogya Raksha Samithi (ARS) of the hospital who has conducted the delivery of a HIV positive ANC	50%	2750 + *825 = 3575	5000
2	To attending Obstetrician on a HIV Positive delivery	25%	1375	2500
3	To attending Anesthetist of a HIV Positive delivery	*15%	NA	1500
4	To attending Staff Nurse of a HIV Positive delivery	6%	330	600
5	To attending Group 'D' of a HIV Positive delivery	4%	220	400
	Total reimbursable budget by FHPL- Yeshaswini Scheme	100%	5500	10000

Note: * 15% of amount released towards Anesthetist's incentive (Rs. 825/-) will be also put into the Arogya Raksha Samithi in case of Normal Deliveries

Achievements: The beneficiary details under Yeshaswini scheme is as follows:

Period	Total Deliveries under YNH	Normal Deliveries	Amount claimed (Rs.)	Caesarean Sections	Amount Claimed (Rs.)	Total Amount claimed (Rs.)
April 2010 to Mar 2011	1120	957	2966520	163	1272800	4239320
April 2011 to Mar 2012	1676	1415	5554460	261	2096800	7651260

April 2012 to Mar 2013	576	476	1802000	100	858000	2660000
April 2013 to Dec 2013	1049	804	4111850	245	2346000	6457850
Total	4421	3652	14434830	769	6573600	21008430

Justification: Institutional delivery of positive pregnant women and the provision of ARV to mother-baby pair can significantly reduce the risk of Parent to Child Transmission. Through KSAPS-NRHM convergence initiatives, positive pregnant women in Karnataka are offered cashless deliveries in a network of public and private sector hospitals and health providers are given incentives for conducting deliveries of HIV positive women. Hence the scheme is very essential to ensure 100% institutional deliveries of HIV positive pregnant women.

Deliverables: 1800 Positive pregnant mothers are expected to undergo institutional deliveries at the Yeshaswini network hospitals.

Funding Proposed:

No of Units*	Cost per unit	Total Cost	FMR code
1800 HIV positive pregnancies	@ Rs 5500 for Normal deliveries @ Rs 10000 for Caesarian Sections	INR 11250000	B.17.3.1

INCENTIVES TO ASHA WORKERS FOR HIV

Activity Proposed: Incentives to ASHAs for mobilizing Positive pregnant women and children for registration and uptake of services

Continued since FY 2010

Approximately 1.2 million pregnancies occur annually in Karnataka State and HIV prevalence in pregnancy from sentinel surveillance was 0.86% in 2008 with a further reduction to 0.69 as per HSS-2010. Since its inception, the PPTCT Program in Karnataka has worked as a vertical program implemented by Karnataka State AIDS Prevention Society (KSAPS). PPTCT activities therefore were not seen as part of the existing health system, and general health resources were not tapped. This resulted in gaps in HIV testing and follow-up for pregnant women. In March 2008, a plan was drafted to integrate the PPTCT program with the NRHM in all 30 districts of Karnataka with a goal to converge PPTCT services with RCH services under NRHM.

The key objectives is to prevent HIV transmission from Parent to Child across Karnataka through the following:

- Universal coverage of all pregnant women with HIV Counselling and Testing

- Strengthening systems for institutional deliveries for all HIV positive pregnant women
- Tracking and ensuring that mother-baby pairs access the continuum of HIV care upto 18 months.

This could be done well by ASHA workers, who can act as a catalyst /bridge between the both RCH and PPTCT .

ASHA Incentives are provided in two stages: Stage I: Ante-natal case for accompanied referral for confirmation of HIV positive status and registration for which an amount of Rs. 100/- to be paid as Incentive. Stage II : Rs 500/- for a) minimum 4 accompanied Ante-natal Checkups and ART initiation b) accompanied institutional delivery and administration of NVP prophylaxis to the baby till 6 weeks after birth c) accompanied minimum 4 Post-natal Checkups for mother and baby at (i) 6 weeks: Early Infant Diagnosis, If positive, ensuring initiation of Paediatric ART, Immunization and CPT Prophylaxis

For mother – Introduction of PP IUD (Cu-T 380-A) and advise on Exclusive Breast Feeds upto 6 months (EBF Only. Ensuring NO MIXED FEEDING. (Feeding the baby both breast milk and alternate formula feeds during the first 6 months)

(ii) 6 months: For baby – Repeat HIV testing and Immunization that is due

For mother - advise weaning, continued breast feeding for HIV negative mothers upto 1 year (iii) 12 months: For baby - Whether primary immunization completed including Vitamin 'A' dose, If negative stop breast feeds and repeat HIV testing after 6 weeks of stopping Breast feeds. If detected positive, refer to ART for treatment (iv) 18 months: For baby – Confirmation of HIV status of baby using Rapid Test at ICTC and Immunization - Booster dose

For father – Motivate for NSV as far as possible and bring him for NSV after consent

For mother – (If male unwilling only despite all endeavors) Advise tubectomy for mother after consent

Justification: ASHA incentives for HIV services has brought accountability among all stake holders towards the well-being of mother and child by ensuring safe motherhood through institutional deliveries and reducing transmission of HIV from mother to child through effective strategies of PPTCT programmes. Hence it is a proven Integrated and a feasible model within the existing health care delivery systems, thus ensuring long term sustainability with no additional costs. It is proposed to continue this scheme this year too.

Deliverables: Approximately 1800 Positive pregnant mothers detected HIV positive and their children are expected to be referred to the nearest hospital for uptake of services.

Funding Proposed: INR 1800000

No of Units*	Cost per unit	Total Cost	FMR code
1800	INR 1000	INR 1800000	B.1.1.3.1.1

PURCHASE OF RTI/STI DRUGS AND CONSUMABLES

Activity Proposed: RTI/STI Drugs and Consumables

Continued since FY 2010

The prevention, control and management of RTI /STI is a well recognized cost effective strategy for controlling the spread of HIV/AIDS as well as to reduce reproductive morbidity among sexually active population. Individuals with STI/RTI have a significantly higher chance of acquiring and transmitting HIV. Moreover RTI /STI is also known to cause use infertility and reproductive morbidity. Controlling RTI /STI helps decrease HIV infection rates and provides a window of opportunity for counseling about HIV prevention and reproductive health.

Syphilis is one of the easily treatable Sexually Transmitted Infection (RTI /STI), which can be transmitted to sexual partners as well as from infected pregnant woman to her new born child. Untreated syphilis is responsible for multisystem complications and other sickness among infected patients and may cause miscarriages, low birth weight and premature delivery in the pregnant woman. Many patients of syphilis are asymptomatic and do not manifest any symptoms of the disease. The National RTI /STI prevention and control program mandates the conduction of a screening test to detect hidden syphilis among all individuals attending STI/RTI clinic as well as pregnant women attending Antenatal Clinic.

The Rapid Plasma Reagin test (RPR Test) or Venereal Diseases Laboratory Test (VDRL Test) are the most commonly used screening tests to detect syphilis among individuals. A qualitative test is followed by a quantitative test. The programme recommends treatment of all RPR reactive patients. As a guideline all RTI /STI attendees should be referred for syphilis and HIV testing.

Achievements: RTI /STI service achievement

Total No. of visits	Syndromic cases diagnosed	RPR / VDRL testes conducted	RPR / VDRL Reactive	Total No. of ANC attendees	Tested for RPR/VDRL	RPR / VDRL Reactive
For the year 2012-13						
137510	127752	59957	712	184723	137329	151
For the year 2013-14						
91230	79745	34983	236	123271	90440	42

CONSUMABLES:

RPR testing Kit requirement for Health facilities (CHC, PHC, Sub division level hospital) 2014-15							
	NRHM STI target	Coverage 50%	Annual pregnancies and General clients- an estimate	Coverage 50%	Total coverage of RPR testing #	Total RPR Kits Required (with 20% buffer and 10% wastage)	Cost @ Rs.300/ Box
	4,00,000	2,00,000	15,50,000	7,75,000	10,50,000	24,000	72,00,000

added 10% wastage and 20% buffer stock

Kit size is assumed to be 50 tests/box yielding 45 tests due to 10% Wastage

Budget needed for procuring RPR KITS is Rs. 72 Lakhs only

Drugs for RTI/STI management will be procured by NRHM at state level and distributed to peripheral health institutions.

DRUG KITS REQUIREMENT FOR RTI/STI TO NRHM HEALTH FACILITIES (CHC, PHC, Sub division level hospital)2013-14			
NRHM Targets (Syndromic cases)	Total no of drug kits required (60% syndromic cases)	Buffer stock (20% of drug kits required)	Total No .of drug kits required
4,00,000	2,50,000	25,000	2,75,000

Approximate amount required for procurement of RTI/STI drugs is Rs.90 lakhs

Funding Proposed:

Particulars	No. of units	Cost per unit	Total cost	FMR Code
RPR Kits	24000	300 per kits of 50 tests kits each	72,00,000	B 16.2.1.1
RTI / STI Drug kits	2,75000	7 types of color coded RTI / STI kits	90,00,000	

Total Budget for RTI/STI Services : Rs. 162 lakhs

A.2 CHILD HEALTH

Introduction:

Ensuring good education, health of children & adolescents are two primary factors which can result in healthy future for the nation. Many initiatives have been taken up by the Central & State Governments to provide preventive, promotive, curative & rehabilitative health care services through evidence based interventions like Integrated Management of Neonatal & Childhood Illnesses, Facility Based Newborn Care, Care of the Malnourished child, School & Adolescent Health care etc.

Through these efforts, Karnataka is one of the 7 States that has achieved the MDG4 goal of reducing the Under 5 Mortality to less than 38 (37 as per SRS 2012).

Situation Analysis

	Source	Statistics
Reported no. of live births (2013-14 upto January)	HMIS (2013-14)	8,29,291
No. of babies weighing < 2.5 kg at birth	HMIS (2013-14)	95401
Crude birth rate	SRS 2012	18.5
Total no. of under five children	Census 2011	6134041

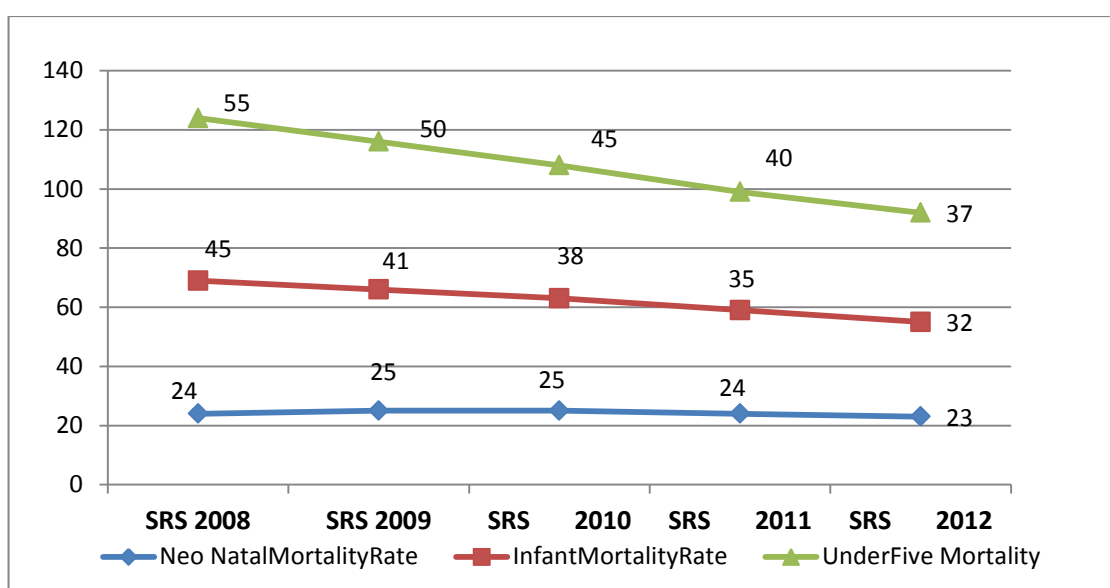
IYCF	NFHS3 (2005-06)	CES 2009
Babies who were breastfed within 1 hour of birth in %	35.6	38.2
Children age 0-5 months exclusively of Breastfed	58	49.8
Nutritional status	NFHS 2	NFHS 3
Children between 0-35 months who are underweight	38.6	33.3
Children between 0-35 months years who are stunted	41.9	42.4
Children between 0-35 months years who are wasted	18.9	25.1
Children between 6-36 months years who are having any Anemia (Hb<11g%)	70.6	83.9
Children between 6-36 months years who are having Mild Anemia (Hb 10 to 10.9g%)	19.6	29.4
Children between 6-36 months years who are having Moderate Anemia (Hb 7 to 9.9g%)	43.3	50.0
Children between 6-36 months years who are having Severe Anemia (Hb<7g%)	7.6	4.6

Though the incidence of anemia has increased, the positive sign is a significant reduction of 3 points in severe anemia.

ARI, Diarrhea&Vitamin A administration	NFHS3 (2005-06)	CES 2009
Children aged 9 months & above who received at least one dose of Vitamin A	22.8	87.1
Children with Diarrhea in the last 2 weeks who received ORS	31	68.8
Children with ARI or fever in the last 2 weeks who were given treatment at facilities.	64.8	90.7

This trend of increased care seeking behavior for ARI and Diarrhea resulted in our achievement of MDG goal in Under five mortality

Child Mortality Indicators



Karnataka has achieved MDG goal of under 5 mortality rate and is 4 points short of achieving MDG goal of IMR. The main concern is the Neo-natal Mortality Rate which has remained static. Hence it is proposed to intensify efforts on Neo-natal care.

Goal:

- To achieve reduction in IMR to less than 23 per 1000 live births by 2017.
- To achieve reduction of Neonatal Mortality Rate to less than 20 per 1000 live births by 2017.

Objective:

1. To improve the quality and utilization of the facility based neonatal care and the quality of the community based neonatal care services.
2. Effective implementation of IMNCI services and nutritional interventions to reduce the under 5 mortality even further.

Strategies:

- Strengthening of Facility based Child care services.
- Community based new born & child care services.
- Capacity building of health care providers in neonatal and child care.
- Optimization of IYCF Practices.
- IEC/BCC activities at all levels.

A 2.1 Integrated Management of Neo-natal & Childhood Illnesses (IMNCI)

IMNCI was initiated in Karnataka as a pilot in Raichur District in 2005-06 & extended to other districts in a phased manner to cover all districts by 2012-13. Till now 1414 Doctors, 4648 Staff Nurses & 9704 ANMs have been trained in IMNCI. Cascading Formats & Case sheets have been supplied to all the districts during 2013-14.

An amount of Rs.31 lakhs had been approved in PIP 2013-14 under Line item A2.1 to conduct State & District Level Co-ordination meetings & undertake Supportive Supervision of IMNCI activities.

Achievements:

Period	Total Live Births	No. Visited within 24 Hours	No. Visited 3 times in 10 Days	0-2 months			2months-5 years		
				No. Assessed	No. Treated	No. Referred	No. Assessed	No. Treated	No. Referred
2012-13	634133 (reported in IMNCI reports)	326514 (51.4%)	435040 (68.6%)	62446	44562 (71.3%)	10969 (17.5%)	107840	82621 (76.6%)	12254 (11.3%)
2013-14 Apr to Dec 2013	517853	247261 (47.7%)	374517 (72.3%)	60378	50469 (83.6%)	9318 (15.4%)	103885	88744 (85.4%)	11817 (11.4%)

Source: Quarterly district IMNCI Reports 2012-13 & 2013-14

- Only 50% of live births have been visited within 24 hours because of the high institutional delivery in Karnataka. There has been a marginal increase of 4% in the visits within 10 days between 2012-13 & 2013-14.
- The treatment rate has also improved between the two years (an increase of 12 -13 %)

Activities:

a) Co-ordination Meetings at State & District levels

It is a continued activity

State level Co-ordination meeting of Officials of Health, Medical Education & Woman & Child Department & District level Co-ordination meeting on the same lines in 30 Districts have been conducted every year from 2011-12

District level Co-ordination meetings have been conducted in all districts during 2013-14. . The activity will be continued at one meeting per district at a cost of Rs.10000/- per district totaling to Rs.3 lakhs.

The State Level Meeting has not been conducted during 2013-14. The State will conduct State level co-ordination meeting with officials from Health & FW, Department of Woman & Child & Medical Education departments during the 2nd quarter @a cost of Rs. 50000.

b) Supportive Supervision of IMNCI in all 30 Districts:

It is a continued activity

IMNCI has been implemented in 14 districts since 2009-10 & gradually scaled up to cover all 30 districts by 2011-12. Rapid assessment undertaken in 2011-12 by experts from Directorate of Health (Karnataka), UNICEF & IHMR (Bangalore) revealed that Supervision of the IMNCI implementation is inadequate.

It was therefore proposed & approved in PIP 2013-14 under Line item A2.1 to conduct Supportive Supervision of IMNCI in 16 Districts by paying an additional incentive to the Medical Colleges which were already engaged in strengthening Routine Immunization.

However, as it was approved to appoint Field volunteers for Immunisation Supervision in the Supplementary PIP, the IMNCI Supportive Supervision was to be undertaken entirely with the funds allotted under IMNCI. Hence it was decided to undertake the activity only in 10 districts through the 10 Government Medical Colleges in Karnataka. The activity has commenced from April 2014 following an agreement with the Medical Colleges to conduct the activity for 1 year. Faculty from the 10 Government Medical Colleges of Bangalore, Mysore, Hubli, Bellary, Raichur, Bidar, Belgaum, Mandya, Hassan & Shimoga will make monthly visits to two PHCs, 4 Sub-centers & Communities in their respective districts. They assess the availability of equipments, utilization of the case sheet, formats, knowledge of the health personnel & implementation of the activity against the guidelines issued. Reports will be submitted every month to the district and State for concurrent correction. State level review of the reports will be taken up quarterly during the Co-ordination meeting.

As the commencement of the activity has been from April 2014, it will be continued till March 2015. An amount of Rs. 30000 per district - for the activity from July 2013 to March 2014 (9 months) is proposed.

Budget per district for 9 months is calculated as follows:

Incentive per team	POL	Stationary cost	Total amount per district in Rupees
18000	9000	3000	30000

Budget for 10 districts: Rs. 3 lakhs @ Rs. 30000 per district

Justification:

- The Co-ordination meetings are an opportunity to appraise the Health, WCD, Medical Education & other related departments of the various Child Health activities. It also provides a platform for dissemination of current guidelines & gives a feed-back of the achievements & gaps in implementation of the various programmes related to Child Health.
- Supportive Supervision will help improve the quality of implementation of the programme, resulting in reducing morbidity & mortality in 'under five' children.

Deliverables:

- Improved quality of assessment and management of sick newborns and children
- Improved identification and referral of malnourished children
- Improved recording and reporting of IMNCI

Funding proposed for IMNCI:

Sl. No.	Particulars	No. of units	Cost per unit in lakhs	Total cost in lakhs	FMR code
1	State level coordination meeting	1	0.5	0.5	A.2.1
2	District level coordination meeting	30	0.1	3.00	A.2.1
3	Supportive Supervision	10	0.30	3.00	A.2.1
	Total			6.5	A.2.1

A2.2 Facility Based Newborn care:-

It is a continued activity.

Serious and concerted efforts have been made to address the needs of a newborn in its first few days in order to reduce Neonatal Mortality in Karnataka. One of the first steps taken in this regard was setting up of 24 x 7 PHCs in a phased manner from 2005-06 and First Referral Units.

Simple known preventive and promotive interventions such as early initiation of breastfeeding exclusive breast-feeding and keeping the baby warm after birth remain the vital factors in tackling newborn mortality.

Essential Newborn care for all births is provided at PHCs, CHCs, Taluka Hospitals & District Hospitals through establishment of New Born Care Corners (NBCCs).

10% of the newborns require specialized services. Low birth Weight or premature newborns, babies needing resuscitation & babies with Jaundice are given initial treatment, stabilized & then referred in appropriate way to the higher centre at the New Born Stabilization Units (NBSU) situated in FRUs.

The provision for specialized services at District Hospitals identified for both essential newborn care and care for sick newborns has been provided through establishment of Specialized Newborn Care Units (SNCU).

Level 1 - NEWBORN CARE CORNER (NBCC):-

1050 PHCs were targeted to be 24X7 PHCs in Karnataka during 2011-12. Considering the higher IMR in Northern Karnataka, all the PHCs of Gulbarga division were notified as 24 x 7 PHCs. Newborn Care Corners were established in Labor Rooms & Operation Theatres in all the 24 x 7 PHCs, CHCs, Taluka Hospitals and District Hospitals by providing them with Radiant warmer & Resuscitation equipments. 2098 Doctors, 4219 Staff Nurses and 4281 ANMs have been trained in NSSK till date.

During subsequent years, though many of the identified NBCCs were not delivery points, the NBCC care has been continued in all the erstwhile identified 24X7 PHCs & FRUs

Abstract of the Facility wise breakup of NBCCs is given below

*** DP – Delivery points, NDP – Non delivery points**

Only those Sub centres identified as delivery points during the year are provided with NBCC. Hospitals from PHC to Taluk level hospitals are provided with NBCC irrespective of whether they are delivery points or not. All District and District level hospitals are identified delivery points.

	2013-14			2014-15		
FACILITY BREAKUP	DP	NDP	Total	DP	NDP	Total
SC	51	0	51	57	0	57
Non 24X7 PHC	67	10	77	60	121	181
24X7 PHC	555	313	868	462	360	822
CHC	122	16	138	134	23	157
Maternity Hospitals	4	2	6	4	0	4
Taluk Hospitals	138	8	146	137	9	146
DH/DLH	25	0	24	24	0	24
Medical College Hospitals	10	0	11	11	0	11
TOTAL	972	418	1390	889	513	1402

Achievements: Abstract of report of NBCCs for the period April 2013 to December 2013 is given below:

	Total Deliveries	Total Live Births	Total No. of Babies Required Resuscitation	Total No. of Babies Referred	Total No. of Babies Died	Total Still Births	% of Babies Required Resuscitation	% of Babies Referred	% of Babies Died	% of Still Births
Level 1 NBCC PHC & Non FRU CHCs	124115	116466	3495	3202	876	3510	2.8	2.7	0.7	2.8
Level 2 NBCC FRU CHCs & TH	135195	137704	6221	4690	1104	6587	4.6	3.4	0.8	4.9
Level 3 NBCC DH, Medical College & DLH	124640	122100	7588	2086	3762	4125	6.1	1.7	3.0	3.3
Total	383950	376270	17304	9978	5742	14222	4.5	2.7	1.5	3.7

Justification for continuation of NBCCs in Non delivery points: It is highly essential to provide Newborn Care Corner facilities in the labour room irrespective of the number of deliveries that take place. Hence NBCC are provided in 1402 facilities irrespective of whether they are delivery points or not. This includes 51 Sub Centres.

Deliverables:

- Safe delivery & essential New born care to all pregnant ladies who access the 1402 facilities for delivery.
- Safe referral to the nearest equipped centres for babies requiring higher level of care

LEVEL 2 - NEWBORN STABILIZATION UNIT (NBSU):

It is a continued activity.

New Born Stabilization Units were established in all 192 identified FRUs by 2011-12. Analyzing the functioning of the units, services of NBSUs in 14 FRUs were withdrawn in 2012-13, but they were continued as NBCCs. Hence the target of NBSU for 2013-14 was reduced to 178. Totally 1546 Doctors & 3707 Staff Nurses have been trained in F- IMNCI till date.

Mildly asphyxiated/ low birth / premature new born babies are cared for in the NBSU apart from providing Level 1 care for all newborns. Most NBSUs are 2-5 bedded.

About 38% of the NBSUs have no Pediatricians & the number doubles in High Priority districts. This is in spite of offering higher salaries in HPDs. Government of Karnataka have taken all steps to fill the vacancy.

Achievements:

Abstract of report of NBSUs for the period April 2013 to December 2013 is given below:

Component	Achievement
Live Births	137704
Still Births	6587
Total Admissions	56256
In-born Admissions	53749
Out -born Admissions	2614
Total Discharges	22490
Out -born Discharges	775
Total Referrals	4690
Total Lama	664
Total Expired	1104

Amongst the functioning NBSUs, 10 NBSUs have more than 40 admissions per month. Most NBSUs have about 10 admissions per month.

Considering the number of deliveries, admissions to NBSUs & proximity to the SNCUs, it has been proposed to downgrade 12 NBSUs to NBCCs during 2014-15. All are in Non High Priority districts except the one in Bagalkote which is in the District Head quarters & close to the District Hospital.

List of 12 NBSUs that will be downgraded to NBCC

Sl. No	District Name	HFD status	Facility Name	Taluk Name
1	Bangalore Rural	NO	(FRU) DEVANAHALLI TALUK HOSPITAL	DEVANAHALLI
2	Tumkur	NO	(FRU) GUBBI TALUK HOSPITAL	GUBBI
3	Shimoga	NO	(FRU) ANADAPURAM	Sagar

4	Hassan	NO	(FRU) ALUR TALUKA HOSPITAL	ALUR A
5	Hassan	NO	(FRU) SAKALESHPUR TALUKA HOSPITAL	SAKALESHPUR A
6	Chikmagalur	NO	(FRU) KOPPA TALUKA HOSPITAL	KOPPA A
7	Chikmagalur	NO	(FRU) MUDIGERE TALUKA HOSPITAL	MUDIGERE A
8	Chamrajnagar	NO	(FRU) YELANDUR TALUKA HOSPITAL	YELANDUR A
9	Mandya	NO	K M DODDI	Maddur
10	Mandya	NO	(FRU) SRIRANGAPATNA TALUKA HOSPITAL	SRIRANGAPATNA A
11	Belgaum	NO	(FRU) HIREBAGEWADI	Belgaum
12	Bagalkote	YES	BAGALKOTE TALUK HOSPITAL (BGK OLD)	BAGALKOTE (OLD)

Justification for continuation of the 166 NBSUs :

166NBSUs will continue to function this year. The following measures will be taken to improve functionalization of NBSUs:

1. F-IMNCI training will be given to regular Doctors of the NBSU irrespective of their Specialty to ensure that one of these Medical Officers can be placed in charge of the NBSU even in the absence of Pediatrician.
2. It is proposed to give 4 Staff Nurses for NBSUs with high delivery load & NBSU admissions. The number of Regular Staff Nurses in the hospital will also be taken into account while allotting the contractual Staff Nurses.
3. Supportive Supervision will be taken up through the Nodal Officers of the District & Consultants

Deliverables:

- Adherence to protocol during admissions& treatment
- Improved record keeping.
- Increase in Out-born admissions

Level 3 -SPECIAL NEW BORN CARE UNITs (SNCU):

It is a continued activity.

33 SNCUs have been established in 22 District & District level Hospitals and 11Govt. Medical College Hospitals by 2011-12. Totally 37 Doctors &197 Staff Nurses have been trained in FBNC. They cater to sick newborns born in these hospitals & those referred from NBSUs &NBCCs.

These Special Newborn Care Units are provided with 12 radiant warmers & other equipments like Phototherapy units, Oxygen Concentrator, etc. and additional Human Resources of 3 Doctors, 12 Staff Nurses & 1 Child Health counselor per unit.

Achievements:

Abstract of report of NBCCs for the period April 2013 to December 2014 is given below:

Components	Report of All 33 SNCUs	Medical College SNCUs(11)	Non-Med College SNCUs(22)
Deliveries	124640	66373	58267
Live births	122100	64058	58042
In-born admissions	20218	10161	10057
Out -born admissions	8748	6017	2731
Total admissions	28966	16178	12788
% of In-born admissions	70	63	79
In-born deaths	2331	1620	711
Out-born deaths	1434	1189	242
Total Deaths	3762	2809	953
NMR	19	25	12

- In-born admissions account for 70% of admissions while 30% are Out-born admissions
- Out-born admissions in Medical Colleges is three times that of Non Medical Colleges .
- New-born Deaths in Medical Colleges is 3 times that of Non Medical Colleges. This indicates that most high risk newborns are admitted in Medical Colleges .

Classification of SNCUs based on admissions

Criteria	No. of SNCUs
SNCUs consistently having >200 admissions	2
SNCUs consistently having 150-200 admissions	4
SNCUs consistently having 100-150 admissions	9
SNCUs consistently having 50-100 admissions	10
SNCUs consistently having <50 admission	08
SNCUs functioning with own funds & having < 50 admns	02

New Proposal:

New SNCU:

1. **District Hospital Bellary** is a newly constructed MCH wing in the heart of the city of Bellary. It is proposed to operationalise an SNCU in this hospital. The equipments have been purchased already. It is proposed to modify the existing SNCU infrastructure & Human Resources as per the guidelines.
2. **Taluk Hospital Sirsi**, has an established NBSU. It is about 150 kms from the District Hospital, Karwar. On an average, 230-250 deliveries occur in this hospital. It is a functional FRU with 2 Gynecologists & a blood bank, but there is no Pediatrician. Considering the distance from the District Headquarters & the terrain which make it difficult for referral, the Local IMA & Rotary branches have donated 6 warmers, 6 Phototherapy units & other accessory equipments, established central Oxygenation and come forward to ensure the services of a local Pediatrician. It is proposed to establish a SNCU in this hospital. The space has been identified & needs modifications to establish a 12 bedded SNCU as per guidelines. An amount of Rs. 10 Lakhs for Infrastructure modification & provision of 3 Medical Officers & 12 Staff Nurses is proposed for this unit.

It is proposed to strengthen 2 SNCUs which have been established through their own funds.

3. **Wenlock Hospital, Mangalore** –Wenlock Hospital, the District Hospital of Dakshina Kannada District has a Regional Advanced Pediatric Care Centre established with funds from a Private Medical College(Kasturba Medical College, a Public sector company (ONGC& INFOSYS). There is no Labour ward in this hospital. Deliveries occur at Lady Goschen, the Woman & Child Hospital about 1-2 kms from this hospital with a 12 bedded SNCU. The Regional Advanced Pediatric Care Centre attached to the District Wenlock Hospital is a tertiary care hospital which caters to critical out-born babies & children referred from Lady Goschen Hospital, FRUs of the district & the neighboring districts of Chikmagalore, Kodagu, Udupi & Hassan. About 312 babies have been managed in this unit from April to December 2013. About 25% of the newborns admitted here are very low birth weight, 10% are cases of Birth Asphyxia, Meconium aspiration etc.

4. Bowring & Lady Curzon Hospital, Bangalore

This is a General Hospital attached to Bangalore Medical College & Research Institute. It is situated in East Bangalore. This is a recognized delivery point having about 4000 deliveries per year. A SNCU has been established in this hospital in 2012 with funds from Medical Education department. There are 6 Radiant warmers, 6 Phototherapy units & other equipments like Multipara monitors, Infusion pumps etc.

There are 4000 deliveries in this institution during 2013. About 663 Inborn & 320 out-born babies are admitted here during 2013. 19% admissions are due to Birth Asphyxia, 24% Preterm & 17 % Sepsis. Sick babies are referred to this unit from HSIS Gosha Hospital, Maternity Hospitals from East & North Bangalore & from the neighboring districts of Kolar & Chikbalapur.

Deliverables:

1. Improvement of infection control practices minimizing the need for un-necessary admissions & antibiotics.
2. Enhancement of Out-born admissions
3. Improving Follow up of discharged babies
4. Optimal utilization of services of SNCU
5. Decreasing neonatal mortality& morbidity

Recurring cost:**Maintenance & Consumables:**

It is a continued activity

Recurring costs include Maintenance & Consumables.

Maintenance costs cover those expenses like electrical& plumbing repairs, minor partitions / alterations, & other such contingency charges. These have not been budgeted under HR, Infrastructure, procurement, training, IEC or any of the other heads

Consumables cover essentials for the newborn like Cord clamps, NGT tubes, etc.

The recurring costs for NBCCs, NBSUs & SNCUs has been worked out taking into account the Delivery load &admissions.

Recurring cost for the SNCUs A2.2.1

It has been observed during the visits that facilities have electrical & plumbing works, minor alterations, etc. as required in the guidelines. A differential costing has been proposed depending on the number of admissions.

Facilities	No. of Units	Maintenan ce costs in lakhs	Consum able costs in lakhs in Rs.	Recur ring cost per SNU in Lakhs	Total recur ring cost in Lakhs
Maintenance cost for SNCU with more than 150 admission per month	10	3.5	1.5	5	50.00
Maintenance cost for SNCU between 50-150 admissionper month	14	2.5	1	3.5	49.00
Maintenance cost for SNCU with less than 50 admissionper month	13	1.5	1	2.5	32.5
					131.5

Recurring cost for the NBSUs A2.2.2

Facilities	No. of Units	Unit cost	Total recurring cost in Lakhs	Remarks
Maintenance cost for NBSU including consumables (more than 150 deliveries)	27	20000	5.4	Rs.10000 per maintenance & Rs.10000 for consumables
Maintenance cost for NBSU (less than 150 deliveries)	139	10000	13.9	Rs.5000 per maintenance & Rs.5000 for consumables
			19.3	

A2.2.1.1 SNCU data Management.

New Activity.

As per the guidelines from the GOI Karnataka state will have a state level cell for SNCU data monitoring, the cell will function under overall supervision and guidance of Deputy Director child health. The main functions of this cell will be:

- Supporting scale up of SNCU online software in the state.
- Monitoring clinical care in SNCU, quality and completeness of clinical data entry.
- Ongoing support and feedback to districts and identifying areas for correcting actions.
- Support data analysis and monitoring of performance of individual unit on different parameters including periodic reviews.
- Coordinate with child health team of Government of India and National cell to resolve software and data related issues as well as getting feedback on state performance.

It is proposed to procure the following hardware based on the need assessment undertaken.

Computers and peripherals (printer and data card, camera)	32 (except Kolar, Vani villas, Indira Gandhi Institute of Child Helath, KIMS Hubli, Bijapur)
Telephone, broad band connection and data card back up	37

It is proposed to recruit following HR as per the directions from the GOI

1. State SNCU Software Coordinator : 1
2. State SNCU Clinical Care Coordinator : 1
3. Dedicated data entry operators for SNCUs: 37

Printing cost of SNCU stationary and case recording for matsfor 2014-15 and trainings of state and district level officials will be supported by UNICEF.

Incentives for ASHA for follow up of SNCU Discharged babies in the community for one year @ of Rs 50 per visit per month as will be budgeted under ASHA component.

SNCU data Management costs A2.2.1.1

1. State SNCU Software Coordinator : 1

Qualification: MCA with 2 year experience or BCA with three year experience of working in health sector especially handling trainings and roll out of software and data management systems for Maternal and New born health especially relating to SNCUs.

Expected Tasks: State SNCU software coordinator will be working closely with the districts for supporting scale up of online system including development of data base, trainings on use of software, capacity development of State level cells and ensuring the required support for roll out of online software in all functional SNCUs of the State. The State SNCU software coordinator would be working in close coordination with regional SNCU software coordinator for the roll out and smooth functioning of Software application.

Salary: Rs.60,000 per month x 6 months = Rs.3,60,000
Travel: Extensive travel across different districts in the State. Travel for around 15 days in a month. Approximate Travel and DA for 15 days in a month, to be kept at Rs. 20,000 per month x 6 months = 1,20,000.

2. State SNCU Clinical Care Coordinator : 1

Basic Qualification: MD Pediatrics & computer knowledge with one year experience or DCH with 2 year experience of working in SNCUs either in government or private sector

Expected Tasks: State SNCU clinical care coordinator will be working closely with the SNCU staff in districts for monitoring quality of care in SNCUs including implementation of Standard treatment protocols, proper maintenance of clinical records and entry of data from clinical records into online software. The coordinator will also provide supportive supervision to SNCUs with onsite correction and clinical mentoring of the staff to identify and address wrong practices in the SNCUs. The coordinator will also support setting up of audit system for all neonatal deaths in SNCUs to be done jointly with Maternity staff.

Salary: Rs.1,00,000 per month x 6 months = Rs.6,00,000

Travel: Extensive travel across the State. Travel for about 15 days in a month. Approximate travel and DSA for 15 days in a month @ Rs.80,000 per month x 6 months = 4,80,000.

3. Dedicated data entry operators for SNCUs: 37

It is important to track the data of the newborns who are admitted in these SNCUs. Real time data and evidence helps in informed decision making and guiding policy. And it is in line with mandate of the SNCU operational guidelines and the letter from the child health division of MOH GOI regarding computerization of the SNCU. These dedicated data entry operators will also follow up the SNCU graduates who are discharged through ASHA. Also they will line list the deaths in SNCUs which will have to be taken up in the proposed Child Death review.

Hence a dedicated data entry operator is proposed to all the SNCUs. The training for these data entry operators will be provided by the Master trainers.

A2.2.1.1 SNCU Data Management	No. of Units	unit cost	Total cost in lakhs	FM R	
State SNCU Software Coordinator	1	0.60	3.6	A2.2.1.1	Salary proposed for 6 months @ Rs.60,000/m
State SNCU Clinical Care Coordinator	1	1.00	6.00		Salary proposed for 6 months @ Rs.1,00,000/m
Dedicated data entry operators for SNCUs	37	0.72	26.64		Salary proposed for 6 months @ Rs.12,000/m
TA / DA for state co-ordinators 1+1	2	1.20	2.40		TA/DA @ of Rs.80,000 for 15 days for 6 months for 2 coordinators
Computers and peripherals (printer and data card,camera)	32	0.8	25.6		
Internet and phone charges	37	0.36	13.32		
Total cost			77.56		

Strengthening of NBCCs, NBSUs & SNCUs

It is a continued activity

Infrastructure :

New SNCU:

Bowring & Lady Curzon Hospital, Bangalore &Wenlock Hospital, Mangalore,District Hospital Bellary:It is proposed to strengthen the existing SNCUs established at their own cost by having a separate in-born & out-born units for In-born & Out-born In Bowring & Lady Curzon Hospital, Bangalore. It is proposed in Wenlock Hospital, Mangalore, to have separate units for preterm, septic & other babies.The District Hospital Bellary is the newly constructed MCH wing in the heart of the city of Bellary. It is proposed to operationalize an SNCU in this hospital. It is proposed to modify the existing SNCU infrastructure as per the guidelines.

Taluk Hospital, Sirsi: Taluk Hospital, Sirsi, has an established NBSU. It is about 150 kms from the District Hospital, Karwar. It is proposed to establish a SNCU in this hospital. The space has been identified & needs modifications to establish a 12 bedded SNCU as per guidelines.

An amount of Rs. 20.00 Lakhs is needed for Infrastructure modification for each of the 4 above mentioned hospitals.

Carry forward /Spillover from previous year's sanction for SNCU:

- 1. District Hospital, Gulbarga:** SNCU of Gulbarga has the highest number of admissions amongst the Non-Medical College SNCUs. The hospital caters to 35% Out-born admissions as there are no Pediatricians in most of the Taluka level hospitals & CHCs. An amount of Rs. 10.00 lakh had been released in Supplementary PIP 2012-13 for strengthening of the SNCU. However, an additional Rs. 22.00 lakh is required to extend the SNCU by establishing an additional Out-born unit & Step down ward.
- 2. District Hospital Mandya:** Mandya District Hospital which was upgraded to Medical College Hospital has a SNCU, which has been improving by an increase of 300 -400 admissions per year over the years with the services of a dedicated Neonatologist. An amount of Rs. 15.00 lakhs had been released in 2012-13 for strengthening of the SNCU. The construction of a Step-down ward & the provision of triage & duty rooms for doctors & Nurses needs to be completed. An additional amount of Rs. 10.00 lakhs is required to complete the repairs.
- 3. District Hospital Koppal:** Koppal District Hospital which was shifted to a newly constructed building. A pediatrician has been posted to this hospital from January 2014. The district had no pediatrician for the past 5-6 years. The SNCU has been improving with 80-100 admissions per month with the services of this dedicated pediatrician. The infrastructural modification for a Step-down ward, out-born and inborn area & the provision of triage needs to be completed. An amount of Rs. 10.00 lakhs is proposed for this.

Strengthening of New SNCUs			
Wenlock Hospital, Mangalore	Step-down , extension of SNCU, duty doctors' rooms, triage & Breast feeding areas	RS. 20 lakhs	B5.6.1
Bowring & Lady Curzon Hospital , Bangalore	Out-born, Step-down , lab, duty doctors' rooms, triage & Breast feeding areas	RS. 20 lakhs	
District Hospital Bellary	Out-born, Step-down , lab, duty doctors' rooms, triage & Breast feeding areas	RS. 20 lakhs	
Taluk Hospital, Sirsi	Out-born, Step-down , lab, duty doctors' rooms, triage & Breast feeding areas	RS. 20 lakhs	
Carry forward /Spillover from previous year's sanction for SNCU :			
District Hospital Gulbarga	Out-born, Step-down , lab, duty doctors' rooms, triage & Breast feeding areas	RS. 22 lakhs	B5.6.2
Mandya DH	Step-down , partitions for OB, triage & Breast feeding areas	Rs.10 Lakhs	
Koppal DH	Out-born, Step-down , triage & Breast feeding areas	Rs.10 Lakhs	

Equipments for FBNC:

SNCU :

It is proposed to strengthen the SNCUs of Bowring & Lady Curzon Hospital Bangalore, & Wenlock Hospital Mangalore which are being included under NRHM & the Medical College Hospital, Gulbarga which is being newly established.

The following equipments are required to strengthen the above centres:

Equipm ent	Wenlock Hospital		Bowring Hospital		District Hospital Gulbarga		Taluk Hospital, Sirsi		Total	
	Existi ng	Requi red	Existi ng	Requi red	Existi ng	Requi red	Existi ng	Requi red	Existi ng	Requi red
Radiant warmers	6	6	6	8	12	6	6	6	30	26
Photothe rapy units	4	3	4	6	4	6	3	3	15	18
Multipara Monitors	6	4	6	5	4	4	0	3	16	18
Infusion pump	4	3	6	4	4	4	2	3	16	14
Syringe pump	6	6	10	7	8	4	1	3	25	20

NBSU:

It has been observed that certain NBSUs have only 1 warmer / Phototherapy unit in their in the NBSU. It is proposed to supply additional warmers to 31 NBSUs & Phototherapy units to 44 NBSUs given in the lists below.

Additional Radiant warmer for 31 NBSUs which have only one warmer.

Sl. No.	District	Name of facility
1	Bangalore Rural	(FRU) NELAMANGALA TALUK HOSPITAL
2	Bangalore Urban	(FRU) ANEKAL TALUK HOSPITAL
3	Belgaum	(FRU) BAILHONGAL TALUK HOSPITAL
4	Bellary	(FRU) SIRAGPPA TALUK HOSPITAL
5	Chikkaballapur	(FRU) BAGEPALLI TALUK HOSPITAL
6	Chikkaballapur	(FRU) GOURIBIDANUR TALUK HOSPITAL
7	Chikmagalur	(FRU) KADUR TALUKA HOSPITAL
8	Chikmagalur	(FRU) KOPPA TALUKA HOSPITAL
9	Chitradurga	(FRU) HIRIYUR TALUK HOSPITAL
10	Chitradurga	(FRU) HOLALKERE TALUK HOSPITAL
11	Chitradurga	(FRU) HOSADURGA TALUK HOSPITAL
12	Chitradurga	(FRU) MOLAKALMURU TALUK HOSPITAL
13	Dakshina Kannada	(FRU) PUTTUR TALUKA HOSPITAL
14	Davanagere	(FRU) CHANNAGIRI TALUK HOSPITAL

15	Davanagere	(FRU) HARIHARA TALUK HOSPITAL
16	Davanagere	(FRU) HARPANAHALLI TALUK HOSPITAL
17	Davanagere	(FRU) HONNALI TALUK HOSPITAL
18	Hassan	(FRU) ARKALGUD TALUKA HOSPITAL
19	Hassan	(FRU) BELUR TALUKA HOSPITAL
20	Haveri	(FRU) BYADGI TALUK HOSPITAL
21	Haveri	(FRU) HIREKERUR TALUK HOSPITAL
22	Haveri	(FRU) SAVANUR TALUK HOSPITAL
23	Haveri	(FRU) SHIGGAON TALUK HOSPITAL
24	Mysore	(FRU) HEGGADADEVANKOTE TALUKA HOSPITAL
25	Mysore	(FRU) HUNSUR TALUKA HOSPITAL
26	Mysore	(FRU) NANJANGUD TALUKA HOSPITAL
27	Ramanagar	(FRU) CHANNAPATNA TALUK HOSPITAL
28	Ramanagar	(FRU) MAGADI TALUK HOSPITAL
29	Tumkur	(FRU) KUNIGAL TALUK HOSPITAL
30	Tumkur	(FRU) TURUVEKERE TALUK HOSPITAL
31	Yadgir	(FRU) SHORAPUR TALUKA HOSPITAL

Additional Phototherapy equipment for 4 1NBSUs

District	Name of the Facility
Bangalore Rural	(FRU) DODDABALLAPUR TALUK HOSPITAL
Bangalore Rural	(FRU) HOSKOTE TALUK HOSPITAL
Bangalore Rural	(FRU) NELAMANGALA TALUK HOSPITAL
Belgaum	(FRU) BAILHONGAL TALUK HOSPITAL
Belgaum	(FRU) SAUNDATTI TALUK HOSPITAL
Bellary	(FRU) ADAGALI TALUK HOSPITAL
Bellary	(FRU) SANDUR TALUK HOSPITAL
Chikkaballapur	(FRU) BAGEPALLI TALUK HOSPITAL
Chikkaballapur	(FRU) GOURIBIDANUR TALUK HOSPITAL
Chikkaballapur	(FRU) GUDIBANDE TALUK HOSPITAL
Chikkaballapur	(FRU) SIDDLAGHATTA TALUK HOSPITAL
Chikmagalur	(FRU) KOPPA TALUKA HOSPITAL
Chikmagalur	(FRU) NARASIMHARAJAPURA TALUKA HOSPITAL
Chitradurga	(FRU) HIRIYUR TALUK HOSPITAL
Chitradurga	(FRU) HOLALKERE TALUK HOSPITAL
Chitradurga	(FRU) HOSADURGA TALUK HOSPITAL
Chitradurga	(FRU) MOLAKALMURU TALUK HOSPITAL
Dakshina Kannada	(FRU) BELTANGADI TALUKA HOSPITAL
Dakshina Kannada	(FRU) PUTTUR TALUKA HOSPITAL
Dakshina Kannada	(FRU) SULTA TALUKA HOSPITAL
Davanagere	(FRU) CHANNAGIRI TALUK HOSPITAL
Davanagere	(FRU) HARIHARA TALUK HOSPITAL
Davanagere	(FRU) HARPANAHALLI TALUK HOSPITAL
Davanagere	(FRU) HONNALI TALUK HOSPITAL
Dharwad	(FRU) KALGHATAGI TALUK HOSPITAL
Dharwad	(FRU) KUNDGOL TALUK HOSPITAL
Dharwad	(FRU) NAVALGUND TALUK HOSPITAL
Hassan	(FRU) ARKALGUD TALUKA HOSPITAL
Hassan	(FRU) BELUR TALUKA HOSPITAL
Haveri	(FRU) HANGAL TALUK HOSPITAL
Haveri	(FRU) HIREKERUR TALUK HOSPITAL
Haveri	(FRU) RANIBENNUR TALUK HOSPITAL
Haveri	(FRU) SAVANUR TALUK HOSPITAL

Haveri	(FRU) SHIGGAON TALUK HOSPITAL
Mysore	(FRU) HUNSUR TALUKA HOSPITAL
Mysore	(FRU) PERIYPATNA TALUKA HOSPITAL
Tumkur	(FRU) CHIKKAAYAKANHALLI TALUK HOSPITAL
Tumkur	(FRU) MADHUGIRI TALUK HOSPITAL
Tumkur	(FRU) SIRA TALUK HOSPITAL
Yadgir	(FRU) SHAHPUR TALUKA HOSPITAL
Yadgir	(FRU) SHORAPUR TALUKA HOSPITAL

NBCC :

Requirement of Radiant warmers in PHCs – 6

Sl. No.	District	Taluk	Facility	Type of facility	Average deliveries per month	Remarks
1	Chamrajnagar	Gundlupet	BARAGI TRIBAL	Non 24 X 7 PHC- NDP	3	Require radiant warmer though they are not delivery points as they are tribal areas
2	Chamrajnagar	Gundlupet	BEGURU	Non 24 X 7 PHC- NDP	2	
3	Chamrajnagar	Yelandur	HANGALA 24X7 TRIBAL	24 X 7 PHC- NDP	4	
4	Chamrajnagar	Gundlupet	TERAKANAMBI (24X7)	24 X 7 PHC- NDP	5	
5	Kodagu	Virajpet	SRIMANGALA 24X7 TRIBAL	24 X 7 PHC- NDP	7	
6	Hassan	Alur	K Hosakote	Non 24 X 7 PHC- NDP	9	Require radiant warmer as the average deliveries is 9

Consolidated List of Equipments required for FBNC :

Type of FBNC	Radiant warmers	Phototherapy Units	Multipara monitors	Infusion pumps	Syringe pumps	Respirators
NBCCs of PHC & CHC	6	0	0	0	0	0
NBSUs of TH	31	41	0	0	0	166
SNCUs	26	18	18	14	20	0
	63	59	18	14	20	166

B16.1.2 Procurement of equipment:

Funding proposed:

Sl No.	Procurement of equipment: CH	No. of units	Cost per unit in Lakhs	Total costIn Lakhs	FMR code
1	Radiant warmers	63	0.75	47.25	B16.1.2.2
2	Phototherapy Units	59	0.5	29.5	
3	Multipara monitors	18	0.5	9	
4	Infusion pumps	14	0.3	4.2	
5	Syringe pumps	20	0.3	6	
	TOTAL			95.95	

Incentives to ASHA under Child Health

The incentive calculation for ASHAs follow up of HBNC, rural LBW , Non LBW SNCU discharge & is as follows

Incentive calculation for HBNC	
	HMIS 2013-14 reports
Total live births	829291
Rural live births @ 61.4% as rural	509185
50% of rural live births (it is expected that 50% of rural Live births will be visited 6/7 times to claim incentive. The number correlates with the HBNC reports of April to December 2013) rounded up number is 255400	255400
Incentive @ Rs. 250 per newborn visited 6/7 times in lakhs	638.50

Incentive calculation for follow up of all LBW babies	
Source -HMIS 2013-14	
Total live births	829291
Total LBW reported	95401
Rural LBW babies @ 61.4% as rural	58481
expecting that 50 % of of rural live births will be visited the completely (6/7 times) as per guidelines	29240
incentive for follow up of he rural LBW babies @ Rs . 50 / baby for 10 months from 3rd mth to 1 yr	32164447
Incentive in lakhs	146

Incentive calculation for follow up of SNCU Non LBW babies	
Source - SNCU 2013 Apr-Dec Reports	
Admissions to SNCU per year	38621
Non LBW admns per year	22671
Non LBW deaths at SNCU	1198
Remaining Non LBW SNCU Babies	21473
50% of remaining Non LBW SNCU babies	10737
Incentive for follow up of the Non LBW babies @ Rs . 50 / baby for 10 months from 3rd mth to 1 yr in Rupees	5368500
Incentive for follow up of the Non LBW babies @ Rs . 50 / baby for 10 months from 3rd mth to 1 yr in Lakhs	53.68

Line listing of LBW & SNCU babies: A sum of Rs.2 lakhs @ Rs. 250 per register is proposed for the 889 delivery points to maintain the line listing of LBW babies & SNCU discharges. Pilot study is under way in Mandya and Mysore districts where LBW babies are provided with innovative home based embrace warmers with close monitoring by ASHAs.

A2.6 Management of Diarrhea

New activity

Introduction:

Karnataka has achieved the Millennium Development Goal of bringing the Under 5 Mortality down to 38. U5MR of Karnataka as per SRS 2012 is 37. However, efforts have to continue to maintain the achievement & reduce it further. About 13 % of children below 5 years die of Diarrhea & 23% die due to Pneumonia in India as per reports from WHO CHERG 2012 (Child Health Epidemiology Research Group).

Diarrhea accounts for 11% of under 5 deaths. As per directions of GOI it is proposed to take up awareness of ORS and Zinc in the management of diarrhea in campaign mode

Diarrheal control assumes great significance due to the following reasons:

- It is not just concerned with deaths
- Causes a significant number of hospitalizations
- Contributes to under nutrition

Objectives:

- Reduction of hospitalization due to diarrhea through promoting usage of ORS & Zinc
- Improving awareness of preventive and promotive practices in reduction of incidence of diarrhea.

Strategies:

1. Appropriate diarrhea management at the facility and community level through reorientation of health care workers.
2. Conducting BCC activity during June and July on ORS and Zinc usage in the management of diarrhea.
3. Setting of ORS corners at facilities during the peak diarrhea seasons.
4. Promotion of personal and household hygiene practices.

Activities:

1. Procurement of ORS & Zinc & distributed to all facilities from Sub Center to District Hospital & also to ASHAs & AWWs.
2. State level Co-ordination cum awareness meeting and video conference will be held during May /June to reorient the district health officials regarding the guidelines of management of diarrhea.
3. Districts level orientation meetings for the medical officers
4. ORS week will be organized at Taluka levels during June/July 2014. Pediatrician & Taluka Health Officers will convey the message of causes of Diarrhea, early signs of dehydration, Demonstration of preparation of ORS & preventive aspects

through skits / PPT to the MOs of the Taluka. Members of IAP will be involved where available.

5. Sensitization of Village Health & Sanitation committees& the ASHAs, AWWs will be undertaken by the Medical Officers during the VHNDs in June / July.
6. IEC materials (Posters etc. regarding ORS-Zinc in Diarrhea) will be supplied to all health facilities (PHC and above)

Funding proposed:

Sl. No.	Particulars	No. of units	Cost per unit in lakhs	Total cost in lakhs	FMR code
1	State level Co-ordination cum awareness meeting and video conference	1	0.25	0.25	A.2.6
2	District level co-ordination and orientation meeting along with the other partners	30	0.01	0.3	
3	Posters Placards, booklets etc. on ORS	10000	0.002	20	
TOTAL				20.55	

A.2.8 Child Death Review.

It is a continued activity of Infant Death Review modified to include Under 5 Child Death Review.

Introduction:

The Government of Karnataka has undertaken measures to bring down the Under-5 mortality rate through many innovative programmes for better antenatal, natal & post-natal and Child care under NRHM. Through these efforts Karnataka has achieved the MDG of under 5 Mortality Rate, which has dropped to 37 per thousand live births which is 1 point less than the MDG. The IMR of Karnataka has decreased from 43 in 2005-06 (NFHS 3) to the latest figure of 32 (SRS 2012).

Child Mortality trends as per SRS survey reports

	2009		2010		2011		2012	
	India	Karnataka	India	Karnataka	India	Karnataka	India	Karnataka
Child Mortality Rate	14	11	13	10	12	9		
Under 5 Mortality rate	63	48	59	45	55	40	52	37
Infant Mortality Rate	50	41	47	38	44	35	42	32
Neonatal Mortality Rate	34	25	33	25	31	24	29	23
Early Neonatal Mortality Rate	27	19	25	22	24	20	23	20
Late Neonatal Mortality Rate	7	5	7	4	7	5	6	3
Post Neonatal Mortality Rate	16	17	14	13	14	10	13	9
Perinatal Mortality Rate	35	36	32	35	30	33	28	33
Still BirthRate							5	14

Analysis of the above reports indicates that the main contributor for the Under 5 mortality is Neonatal Mortality, especially Early Neonatal Mortality, which has not reduced in the past 4 years. Further analysis reveals an alarming trend of an increase in Perinatal Mortality. The only 2 indicators that are higher than the Indian figures are the Perinatal Mortality rate & Still Birth Rate.

Achievements:

Verbal Autopsy is conducted for every infant death in a structured format by the PHC medical officer.

District level infant death review meetings are conducted once a month under the chairmanship of deputy commissioner. Four deaths were reviewed in details- one each from the district hospital, taluk hospital, PHC and the community.

State level Infant death review meeting was conducted once a year under the chairmanship of Director of Health and family welfare services with pediatricians

and neonatologist from medical colleges and private hospitals along with the program officers of RCH.

The report of Infant Deaths collected from the Districts from April to December 2013 through Infant Death Review Programme is as follows:

Sl. No.	Indicators	Reported numbers April to December in the Infant death review programme 2013
1	Live Births	652844
2	Infant deaths	9626
3	Neonatal deaths	7203
4	Home deaths reported	3805

Over the years the reporting of infant deaths has improved but the review has not been producing the expected outcome of addressing the preventable factors.

Activities Proposed for 2014-15:

As per the draft of the Child Death Review Guidelines

- The Line item A2.8 will be changed to Child Death Review instead of Infant Death Review.
- State Level task force is being constituted under the chairmanship of Principal Secretary, Health & Family Welfare Services and will meet twice in a year.
- All deaths under 5 years will be included for verbal autopsy
- Facility & Community based line listing of all under 5 deaths will be undertaken.
- In view of the high still births in SNCUs, line listing of still births of SNCUs will also be under-taken.
- Detailed Guidelines will be drafted following the first State Level meet.
- A minimum of 4 neonatal, 1Post-neonatal, 1 child (1-5 years) deaths in the District will be investigated in detail every month.
- The district level review meeting will be conducted quarterly &the report submitted to the state.
- Training will be undertaken as per guidelines.
- To lay stress on reduction of Perinatal mortality, the maternal and child health divisions of the state will undertake verification of the investigations of 2 Early neonatal deaths & 2 still Births from each District Hospital at least twice in the year. The TA & DA for these teams will be borne out of Programme Management costs.

Funding proposed:

- An incentive of Rs. 500 (Rs. 100 from NRHM &Rs. 400 from State Budget) being paid to ASHAs for reporting infant deaths will be continued., the Incentive will be paid for reporting any death from the Community below 5 years reported by the ASHA.
- An incentive of RS. 200 will be paid to the ANM who conducts the First Brief Investigation & submits a complete report within one month of notification.

- The investigation team consisting of 2 members conducting the detailed investigation will be paid Rs.750 per team per fully investigated & reported case within one month of receiving the FIR

Based on the number of infant death reported in 2012-13 and 13-14 which was 12,560 and 12,834 respectively and the child deaths (1-5 years) at 8 per 1000 live births (SRS 2012), the number of deaths to be line listed is estimated at 15000.

Particulars	Estimated deaths per year
Infant deaths (including neonatal deaths)	13000
1-5 deaths (13.5% of Under five Mortality is 1-5 deaths)	2000

Printing of formats will be for all 15000 deaths but incentives for ANMs & ASHAs is estimated for 4000 as training in new CDR guideline is expected to be completed by 3rd quarter & complete entries may not be possible immediately.

Justification:

The approach as per the national guidelines of conducting the under five child death review will help address the preventable cause of all under five mortality. This will help in the line listing of under five deaths. Also the number of deaths reported may increase with incentives at various levels.

Deliverables:

All under 5 deaths to be reported & investigated.

Compulsory review of under 5 deaths at the District level with actionable report submission to the State.

Funding proposed for child death review

Sl. No.	Particulars	No. of units	Cost per unit in Lakhs	Total cost In Lakhs	FMR code
1	Incentive to ASHA	4000	0.001	4	A2.8
2	Incentive to ANM	4000	0.002	8	
3	Investigation team	1300	0.0075	9.75	
4	Printing of Notification cards (duplicate)	15000	0.0001	1.5	
5	Printing of verbal Autopsy forms (triplicate)	15000	0.0002	3	
6	State level committee meeting	2	0.5	1	
7	District level committee meeting	120	0.05	6	
	Total			33.25	

A2.10 JSSK for sick infants upto 1 year of age

This is a continued activity.

In this programme, free entitlement is provided for all sick neonates upto 1 year admitted in Government Hospitals in the form of care, drugs, investigations & transportation.

Achievements

No. of Beneficiaries Availed free entitlements under JSSK (April to February 2013)				
Drugs		Diagnostics		Referral Transport
Target for neonates	Achievement	Target for neonates	Achievement	Home to facility
60000	65720	48000	36319	Not captured in the report. Will be captured from 2014-15

Proposal for 2014-15

As per estimates, 10% of newborns will need some intervention & 1% of them will need admission to SNCU/NBSU.

However, as the programme has been extended to cover infants i.e. from birth to 1 year, the estimated children are calculated as 15% of live births.

There are about 8.5 lakh births per year out of which about 6 lakhs (70%) access Govt. Institutions.

15% of 6 lakhs is 90000.

All 90000 will be budgeted for drugs, & diagnostics each at Rs 300 per beneficiary considering the costs of drugs & investigations.

Drop back is budgeted for 50% of the 90000 beneficiaries as all the beneficiaries may not seek transport.

Justification:

Extension of JSSK up to one year age will reduce the out of pocket expenditure and increase the utilization of the upgraded public health facilities.

An average amount of Rs 300 per beneficiary is necessary to meet the expensive investigation and drugs of certain patients.

Deliverables:

Increase in the number of beneficiaries under JSSK.

Budget proposed :

Sl. No.	Particulars	No. of units	Cost per unit in Lakhs	Total costing in Lakh Rupees	FMR code
1	Drugs(other than those procured under general drugs for child health & consumables for FBNC)	90000	0.003	270.0	A2.10.1
2	Diagnositcs	90000	0.003	270.0	A2.10.2
3	Free transport	45000	0.003	135.0	A2.10.3
Total				675	

A2.11.1 Retinopathy of Prematurity

It is a continued activity.

Over one-third of the world's blind children live in our country. Childhood blindness in India accounts for a serious health problem. With improving infant mortality indices in Karnataka, survival, particularly of low birth weight infants and premature infants is increasing. These infants are particularly at risk of serious causes of blindness, especially Retinopathy of Prematurity (ROP), that is largely preventable and treatable if detected on time. Retinopathy of Prematurity (ROP) affects about 37- 54 % preterm babies with birth weight less than 2 kg, out of which 5 – 15 % would require treatment. The ideal age for screening is at 21 days of age. However, as studies have shown, many cases would be missed if this schedule is adhered to. Therefore, babies are screened before discharge from Hospital.

Strategies:

- Public Private partnership with Ophthalmic Institutes
- Screening babies weighing below 2000gms at birth for ROP
- Internet assisted diagnosis where babies are screened by trained technicians & images are transmitted to Super Specialists.
- Laser treatment for babies at the public facility by the Super Specialists.

Achievements :

Initiation of the programme: Screening preterm babies for ROP is being implemented through a PPP Project between NRHM & Narayana Nethralaya which was initiated in 2009. This was piloted in the 6 "C" Districts of Northern Karnataka (Gulbarga, Raichur, Koppal, Bidar, Bagalkote & Bijapur with Head Quarter at Raichur). Teams of Ophthalmologists & Ophthalmic Assistants working in Government Hospitals were trained to screen the babies using Retcam.

The programme was implemented at Raichur in February 2011. The PPP project with NarayanaNethralaya was extended from 1st April 2012 to 31st March 2015.

Extension of the project in 2012-13:An additional 6 districts of Central Karnataka with Head Quarter at Davanagere(Dharwad, Gadag, Haveri, Bellary, Davanagere&Chitradurga) are being covered along with the 6 districts of Northern Karnataka. Teams of Government Ophthalmologists &Technicians from these Districts have also been trained.

A third Retcam has been in use at the Minto Ophthalmic Research Institute attached to Bangalore Medical College& Research Institute(BMCRI) from November 2012. The team from Minto Hospital screens preterms from the SNCU of the neighbouringVani Vilas Children's Hospital which is also attached to BMCRI.

Extension of the project in 2013-14 :The Southern Districts of **South Karnataka Project(10 Districts)**with Bangalore as Head Quarters covering Bangalore(Rural), Bangalore (Urban), Ramnagar,Mandya, Mysore, Chamarajanagar, Kodagu, Kolar, Chikballapur, Tumkur are being covered by Vittala International Institute of Ophthalmology through an MOU from 1st February 2014 to 31st March 2015.

The project to cover West zone has to be retendered and will be done soon after the code of conduct .

Achievements:

Particulars	NarayanaNetralaya postgraduate institute of ophthalmology.			Minto regional institute of ophthalmology		Vittala International institute of ophthalmology	State total since inception 2011-12
	2011-12	2012-13	2013-14	2012-13	2013-14	2013-14 (from Feb 2014)	
No. Babies Imaged	598	1297	1168	201	546	69	3879
No. with ROP	143	515	163	103	181	0	1105
No. Treated	33	47	18	10	15	0	123

Justification: Considering the lifelong morbidity caused by the blindness due to prematurity, especially with the increasing survival of premature babies, it is necessary to screen all preterm babies and treat at the earliest.

Deliverables: All premature newborns of district hospitals are to be screened before discharge. Improve referrals of premature newborns from the periphery through ASHAs. Follow up and treatment of all detected cases in SNCUs and DEICs .

A2.11.1 Budget for Retinopathy of prematurity : Considering that the MOU with Narayana Nethralaya & Vittala Institute of Ophthalmology is till March 2015 & the amount kept as Committed expenditure cannot be used beyond September, an amount of Rs,. 10 lakhs is proposed for each of the three zones. A sum of Rs.30 lakhs is proposed for the West zone project which will be awarded following the re-tender process.

Sl. No.	Particulars	No. of units	Cost in Lakhs	FMR code
1	North zone Narayana Nethralaya	1	10	A2.11.1
2	Central zone Narayana Nethralaya	1	10	
3	South zone VIIO (from February 2014)	1	10	
Total		3	30	

A 2.11.3 Evaluation of SNCUs:

Continued activity.

Evaluation of SNCUs will help in supportive supervision, corrective action where necessary & appreciating & emulating the good practices of better performing SNCUs.

An amount of Rs. 16 Lakhs was allotted under line item A.2.11.3 for Evaluation of SNCUs in 2013-14. The award of contract has been delayed because of tendering & re-tendering & Elections. Contract has been finalised to be awarded to a Medical College & an agreement is being finalized. Hence the activity is being carried over.

For the current year, it is proposed to undertake evaluation of the SNCUs through existing Population Research Centers . This being a professional body to which the project can be allotted directly, it will alleviate the tendering process which resulted in the delay in execution of the project during 2013-14.

Teams from the Population research center along with one member from the State Child Health division will visit the 37 SNCUs over a period of one month. SNCUs will be assessed based on the MNH tool kit & report submitted.

A broad Break-up of the Proposed budget of Rs. 14 lakh is given below :

Budget line	Amount in Rupees
Honorarium	500000
Travel	200000
Accommodation	300000
Daily Allowance	100000
Contingency	100000
Reporting	100000
Miscellaneous	100000
TOTAL	Rs. 14 lakhs

Justification :

In-spite of guidelines both from the centre & the State , it has been noticed that protocols are not adhered to, due to mis-interpretation of the guidelines, local difficulties,etc. such things can be clarified on a one-to one basis during these visits .

The evaluation will also help in noticing the good practices / changes needed which can be brought to the notice of the GOI for incorporation in further guidelines.

Deliverables:

Improvement in the functioning of SNCUs

Sl. No.	Particulars	No. of units	Cost in Lakhs	FMR code
1	SNCU evaluation	1	14	A2.11.3

B.16.2.2.4 Pediatric intensive care units PICU**It is a continued activity**

Though Karnataka has achieved the MDG of Under 5 mortality at 37 as per SRS 2012, it is intended to sustain and decrease it further. It had been decided to establish 5 bedded Pediatric Intensive care units in 15 District Hospitals during 2012-13 - Bijapur, Bagalkot, Kolar, Chitradurga, Chamarj Nagar, Haveri, Gadag, Madikeri, Chikmagalur, Tumkur, Davanagere, Dharwad, Udupi, Mangalore, Gulbarga. These PICUs provide facility based intervention for treatment of severe Pneumonia, Diarrhea & other child hood illnesses. They were provided Ventilators & other equipments. Provision has been made for appointment of one Pediatrician & 3 staff nurses on contract basis to these hospitals. The Staff were trained at the PICUs of IGICH, Wenlock & Davanagere.

Consumables cost and Maintenance cost (endotracheal tube, connectors, infusion sets, minor repairs of equipments, electric connections, plumbing etc.) at Rs. 0.50 lakh per PICU is Rs. 7.5 lakhs.

Achievements:

Total no. of children admitted in the 15 Hospitals	No. of children Admitted to PICU	Number treated with ventilator	Number referred	No. of Deaths	No. of Pediatrician trained	No. of Staff Nurses trained

19179	2049	180	279	94	12	27
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Justification:

Since the JSSK is extended upto 1 year, children requiring intensive care will be treated at PICU. Hence the PICUs are continued.

Deliverables:

Sustaining the trend in reduction of the under five mortality

Funding proposed

Sl. No.	Particulars	No. of units	Cost per unit in Lakhs	Total costing Lakhs	FMR code
1	Consumables for Pediatric intensive care units(endotracheal tube, connectors, infusion sets etc)	15	0.50	7.5	B.16.2.2.4

A2.11.State and district level workshops & meetings

New activity

A.2.11.5State level child health workshop

It is proposed to conduct the state level child health workshop on the lines of national workshop to review the programs and disseminate the latest guidelines. This workshop also helps in coordinating with various sections and departments.

Participants for the state workshop

RCH Officers	30
Medical Colleges	10
District Surgeons / Medical superintendents from district level hospitals	25
State officers	45

Budget for State level child health workshop

Name of Particulars	Unit cost	Number of units	Total
Audio Visual arrangement	0.15	1	0.15
Meeting hall with lunch	0.02	110	2.2
Stationery with folder	0.005	110	0.55
Faculty accommodation	0.035	3	0.105
Faculty Honorarium	0.025	4	0.1
Faculty Transport	0.15	2	0.3
Misscellaneous	0.1	1	0.1
Total			3.505

A.2.11.2Video conference to disseminate the child health guidelines to DHs and THs

It has been observed that most of the guidelines do not reach the SNCUs,NBSUs. Hence it is proposed to disseminate the guidelines to the administrative heads and pediatricians of district, taluk and CHCs hospitals. They will be reached through video link form Vikasa Soudha Bangalore to the districts. The guidelines of child health division will be discussed in detail.

Break-up of participants is given below.:

Sl. No	Particulars	Numbers
1	District and district level hospitals(AMO & Peadatirician)	50
2	Taluk health officers and AMO / Pediatricians of hospitals	468
3	CHCs with NBSU(AMO/Pediatrician)	24
4	State level officials (CH division & Nodal officers)	35

Budget :

Sl.no	Particulars	No.	Unit cost for refreshment, Stationary, etc.	Total cost
1	District and district level hospitals	50	0.0085	0.425
2	Taluk hospitals	468	0.0085	3.978
3	CHCs with NBSU	24	0.0085	0.204
4	State level officials	35	0.0085	0.298
				4.90

A.2.11.4 Satellite program on RMNCH+A

To convey the nuances in the RMNCH+A initiative to the grass root workers, it is proposed to reach them through satellite based interactive learning sessions relayed from Mysore to the respective taluks.

Members for the Satellite program: Medical officers and staff nurses from the PHCs and ANMs focusing on the delivery points and NBCCs.

Name of Particulars	Number of units
MOs	900
SNs	900
ANMs	8000
	9800

Batches of 30 will assemble in the taluk panchayath satellite receiving station along with the THO .

There will be 4 hours of teaching session with 2 hour question answer session spread over morning and afternoon everyday for 6 days.

The RMNCH+A program officers and experts will participate from Mysore.

Sl.no	Particulars	Numbers	Unit Cost in Rupees	Budget in Lakhs
1	Trainees	9800	0.0025	24.5
2	Rent for satellite Stations in 176 Talukasfo 6 days	1056	0.01	10.56
3	Generator rent 176 Talukasfo 6 days	1056	0.01	10.56
4	Rent for satellite Station at Mysore for 6 days	6	0.04	0.24
5	Faculty @ 1500 for 6 days	5	0.045	0.225
6	Accommodation for 6 days	5	0.021	0.105
7	Misscellaneous	1	0.025	0.025
				46.215

B 16.2.2.3.Drugs for Children

It is a continued activity

The requirement of drugs from Sub centre to District Hospital (8871 SCs, 2450 PHCs, 188 CHCs, 146 THs & 29 DHs) has been estimated based on the population & the utilization in the previous years Iron & Folic acid, Albendazole, Vitamin A & Consumables for NBCC, NBSU & SNCU have not been included in this estimate. The summary of the budget required at various levels is given in the following table

Type of facility	Estimated amount in lakhs
Sub Centre	252.5
Primary Health Centres	267
Communiy Health Centres&Taluk Hospitals	270
District Hospitals	248
Total1038.5	1037.5

Sub centres are given only Paracetamol, CPM/ Cetrizine, Co-trimoxazole, Zinc, ORS, Gentian violet, IFA, Albendazole.

PHCs are given all above & Amoxycillin, Inj Gentamicin, Amikacin , Salbutamol nebulizer solution, Salbutamol, Metronidazole & Vitamin K.

FRUs are given IV fluids, Phenobarbitone,Phenytoin, etc.

The details of the requirement of individual drugs & costing is given in the following table

Requirement of Drugs for Child Health all facilities. Excluding Iron & Folic acid, Albendazole, Vitamin A & Consumables for NBCC, NBSU & SNCU										
Total for all facilities			Sub Centres		PHCs		CHC & TH		DH	
Name of the drug	Quantity required	Cost in Lakhs	Quantity required	Cost in Lakhs	Quantity required	Cost in Lakhs	Quantity required	Cost in Lakhs	Quantity required	Cost in Lakhs
No. of bottles of Paracetamol Suspension	2095810	168	628743	50	628743	50	419162	34	419162	34
Cetirizine syrup	139721	33	0	0	41916	10	41916	10	55888	13
Trimethoprim & Sulphamethoxazole Suspension IP	698603	63	349302	31	209581	19	139721	13	0	0
Amoxycillin(125 mg Dispersible Tablets IP)	52395	19	0	0	26198	9	13099	5	13099	5
Amoxycillin(125 mg /1ml ,10 ml bottle IP)	50000	12.5	50000	12.5						
Amoxycillin(250 mg Dispersible Tablets IP)	87325	60	0	0	43663	30	21831	15	21831	15
cefadroxil (125 mg Dispersible Tablets IP)	52395	32	0	0	0	0	26198	16	26198	16
Injection gentamicin 80MG per 2ML 1X1 vial	104791	4	0	0	20958	1	52395	2	31437	1
Injection amikacin 250MG per 2ML vial 1X1	174651	6	0	0	34930	1	87325	3	52395	2
Injection amikacin 100MG per 2ML vial 1X1	174651	5	0	0	34930	1	87325	3	52395	2
Cefotaxime Sodium Injection IP	174651	14	0	0	0	0	87325	7	87325	7
Salbutamol Inhalation liquid Ip	174651	9	0	0	34930	2	52395	3	87325	4
Salbutamol Inhalation liquid Ip	104791	6	0	0	31437	2	31437	2	41916	2
Salbutamol Tablet	349302	18	0	0	104791	5	104791	5	139721	7
Domperidon tablets	69860	14	6986	1	13972	3	20958	4	27944	6
Zinc Sulphate Dispersible tablets USP	1047905	210	523953	105	314372	63	104791	21	104791	21
Oral Rehydration Salts IP	2095810	105	1047905	52	628743	31	209581	10	209581	10
Metronidazole suspension	69860	7	0	0	20958	2	20958	2	27944	3
Menadione Injection USP	251379	39	0	0	125690	20	75414	12	50276	8
Phenobarbitone Injection IP	69860	9	0	0	0	0	34930	5	34930	5
Phenytoin Injection BP	69860	7	0	0	0	0	34930	4	34930	4

Isolyte P	349302	45	0	0	0	0	174651	23	174651	23
Dextrose 10%	349302	49	0	0	0	0	174651	24	174651	24
Dextrose Inj 25%	104791	66	0	0	0	0	52395	33	52395	33
Gentamycin Eye drops	349302	35	0	0	174651	17	139721	14	34930	3
Gentian Violet	22853	2	13712	1	9141	1	0	0	0	0
		1037.5		252.5		267		270		248

Calculation of beneficiaries for NATIONAL IRON PLUS INITIATIVE -
Iron & Folic Acid for 6 months to 5 years

Census 2011

age	total	rural	urban
0	933645	585530	348115
1	1017674	610927	406747
2	1010479	643739	366740
3	1042923	670442	372481
4	1041998	668857	373141
5	1087322	691487	395835
	6134041	3870982	2263059

Children accessible to government services

0-5year children

70% rural	2709687
20 % urban	452612
Total	3162299
50% will take complete treatment (1581150) rounded to	1600000

Total 16 lakh

10 % buffer – 1.6 lakh

Rounded to 18 lakhs IFA suspension

Number of bottles of 100ml containing 20 mg elemental iron and 100 microgram of folic acid /ml required @ 1 bottle per child (1ml /child 2 times a week for 1 year) : 18 lakhs

Cost per bottle :Rs. 20

Cost of 18 lakh bottles of IFA suspension for children aged 6 month to 5 years :
Rs. 360 lakhs

National Iron Plus Initiative (Drugs&Supplies)	No. of units	Cost per unit in Lakhs	Total costIn Lakhs	FMR code
IFA syrups (with auto dispenser)	1800000	0.0002	360	B.16.2.2.1.

Albendazole

0-5 children		Albendazole	No. of tablets
6mths -1yr	140000	Nil	0
1-2 yrs	150000	1 tablet / child /year	150000
2-5 yrs	1300000	2 tablets per child /year	2600000
Total	1590000 (rounded to 1600000)		2750000 + 275000 buffer stock = 3025000 tablets

Innovations:

Proposal to address Early Neonatal Mortality which is the main contributor for Infant Mortality.

Though Karnataka has achieved many a milestone in the health sector as shown in the improvement of indicators in areas in child health, the last mile is still awaited. This is mainly because of the high Early Neonatal & Perinatal mortality.

	2009		2010		2011		2012	
	India	Karnataka	India	Karnataka	India	Karnataka	India	Karnataka
Infant Mortality Rate	50	41	47	38	44	35	42	32
Neonatal Mortality Rate	34	25	33	25	31	24	29	23
Early Neonatal Mortality Rate	27	19	25	22	24	20	23	20
Perinatal Mortality Rate	35	36	32	35	30	33	28	33

It is proposed to address these issues through the following innovations:

Provision of Baby respirators for NBSU

New activity

About 2 lakh deliveries have occurred in 178 FRUs of Karnataka identified as NBSUs during 2013-14. About (10%) of these have been asphyxiated. 20% of these asphyxiated babies have expired.

There is an acute shortage of Pediatricians with about 50% vacancy which rises to 80% in HPDs. Even in FRUs where Pediatricians are appointed, they cannot attend to all asphyxiated babies because the single Pediatrician has to also attend to Out-patients & other duties of the hospital. Hence Staff Nurses have been trained in SBA & NSSK to resuscitate newborns using Ambu Bag & Mask. However, in their vigor & enthusiasm to resuscitate the asphyxiated baby in the emergency situation, they might inadvertently use increased pressure. This can lead to complications like Broncho Pulmonary Dysplasia & Emphysema.

These Baby Respirators which are user-friendly & can be easily managed by the Staff Nurse are available for resuscitation of severely asphyxiated babies. The advantage with these equipments is that the Pressure is pre-adjusted, thus avoiding use of less or excessive pressure during resuscitation. In addition, the hands of the resuscitator are free & hence a single resuscitator can give both PPV & Chest Compressions simultaneously in cases where both need to be administered.

The Equipment is small & portable. It is proposed to provide 1 such equipment to 46 NBSUs in the High Priority districts during 2014-15 @ a cost of Rs. 1 lakh per equipment.

Name of the District	Name of the Taluk	Type of facility	Name of the NBSU
Bagalkote	BADAMI	Taluk Hospital	(FRU) BADAMI TALUK HOSPITAL
Bagalkote	BILAGI	Taluk Hospital	(FRU) BILAGI TALUK HOSPITAL
Bagalkote	HUNGUND	Taluk Hospital	(FRU) HUNGUND TALUK HOSPITAL
Bagalkote	JAMKHANDI	Taluk Hospital	(FRU) JAMKHANDI TALUK HOSPITAL
Bagalkote	MUDHOL	Taluk Hospital	(FRU) MUDHOL TALUK HOSPITAL
Bagalkote	Hunagund	CHC	(FRU) ILKAL
Bagalkote	Jamakhandi	CHC	(FRU) RABAKAVI BANAHATTI
Bagalkote	Mudhole	CHC	(FRU) MAHALINGAPUR
Bagalkote	BADAMI	CHC	(FRU) GULLEDAGUDA
Bellary	ADAGALI	Taluk Hospital	(FRU) ADAGALI TALUK HOSPITAL
Bellary	HAGRIBOMMANAHALLI	Taluk Hospital	(FRU) HAGRIBOMMANAHALLI TALUK HOSPITAL
Bellary	HOSPET	Taluk Hospital	(FRU) HOSPET TALUK HOSPITAL
Bellary	KUDILGI	Taluk Hospital	(FRU) KUDILGI TALUK HOSPITAL
Bellary	SANDUR	Taluk Hospital	(FRU) SANDUR TALUK HOSPITAL
Bellary	SIRAGPPA	Taluk Hospital	(FRU) SIRAGPPA TALUK HOSPITAL
Bijapur	BASAVANABAGEVADI	Taluk Hospital	(FRU) BASAVANABAGEVADI TALUK HOSPITAL
Bijapur	INDI	Taluk Hospital	(FRU) INDI TALUK HOSPITAL
Bijapur	MUDEBIHAL	Taluk Hospital	(FRU) MUDEBIHAL TALUK HOSPITAL
Bijapur	SINDGI	Taluk Hospital	(FRU) SINDGI TALUK HOSPITAL
Bijapur	Muddebihal	CHC	TALIKOTI
Gadag	MUNDARGI	Taluk Hospital	(FRU) MUNDARGI TALUK HOSPITAL
Gadag	NARGUND	Taluk Hospital	(FRU) NARGUND TALUK HOSPITAL
Gadag	RON	Taluk Hospital	(FRU) RON TALUK HOSPITAL
Gadag	SHIRAHATTI	Taluk Hospital	(FRU) SHIRAHATTI TALUK HOSPITAL

Gadag	Ron	CHC	GAJENDRAGHAD
Gadag	Shirahatti	CHC	LAKSHMESWAR
Gulbarga	AFZALPUR	Taluk Hospital	(FRU) AFZALPUR TALUK HOSPITAL
Gulbarga	ALAND	Taluk Hospital	(FRU) ALAND TALUK HOSPITAL
Gulbarga	CHINCHOLI	Taluk Hospital	(FRU) CHINCHOLI TALUK HOSPITAL
Gulbarga	CHITAPUR	Taluk Hospital	(FRU) CHITAPUR TALUK HOSPITAL
Gulbarga	JEWARGI	Taluk Hospital	(FRU) JEWARGI TALUK HOSPITAL
Gulbarga	SEDAM	Taluk Hospital	(FRU) SEDAM TALUK HOSPITAL
Koppal	GANGAWATHI A	Taluk Hospital	(FRU) GANGAWATHI TALUKA HOSPITAL
Koppal	KUSHTAGI A	Taluk Hospital	(FRU) KUSHTAGI TALUKA HOSPITAL
Koppal	YELBURGA A	Taluk Hospital	(FRU) YELBURGA TALUKA HOSPITAL
Koppal	Gangavati	CHC	KARATAGI
Koppal	Koppal	CHC	HIRESINDOGI
Koppal	Yelburga	CHC	KUKKANOR
Raichur	DEVADURGA A	Taluk Hospital	(FRU) DEVADURGA TALUKA HOSPITAL
Raichur	LINGSAGUR A	Taluk Hospital	(FRU) LINGSAGUR TALUKA HOSPITAL
Raichur	MANVI A	Taluk Hospital	(FRU) MANVI TALUKA HOSPITAL
Raichur	SINDHANOOR A	Taluk Hospital	(FRU) SINDHANOOR TALUKA HOSPITAL
Raichur	Lingsagur	CHC	MUDAGAL
Yadgir	SHAHAPUR A	Taluk Hospital	(FRU) SHAHPUR TALUKA HOSPITAL
Yadgir	SHORAPUR A	Taluk Hospital	(FRU) SHORAPUR TALUKA HOSPITAL
Yadgir	Yadgir	DH	YADGIR DISTRICT HOSPITAL

Justification:

Provision of Respirators will help in better management of babies needing resuscitation at birth alleviating inadvertent use of increased / decreased pressure during resuscitation which are harmful to the neonate.

Deliverables :

Decrease in incidence of asphyxiated neonates developing HIE

Decrease in referrals from NBSU to SNCU

Decrease in morbidity & mortality resulting due to Asphyxia

Budgeting :

Cost of each equipment is estimated at Rs. 1 lakh.

Total budget required for purchase of 46 equipments is Rs. 46 lakhs

Provision of C-PAP Equipment to SNCUs of HPDs.

A continuous level of positive airway pressure needs to be maintained in a spontaneously breathing preterm infant whose lungs have not yet fully developed. C-PAP results in a decrease in the incidence of bronchopulmonary dysplasia. In some preterm infants whose lungs haven't fully developed, CPAP improves survival and decreases the need for intubation, Surfactant, etc and allows safe respiratory management at lower FiO2 levels, and thus reduces the risk of retinopathy of prematurity or other forms of oxygen toxicity..

Statistics of management of Respiratory Distress Syndrome from the 7 SNCUs during 2013-14 is given below :

Name of the SNCU	Admns			Deaths		
	in-born	out-born	total	in-born	out-born	total
	Respiratory Distress	Respiratory Distress	Respiratory Distress	Respiratory Distress	Respiratory Distress	Respiratory Distress
Bijapur, District Hospital	2	18	20	2	7	9
Gadag, District Hospital	0	5	5	0	1	1
Bagalkote, District Hospital	1	1	2	1	0	1
Gulbarga, District Hospital	8	47	55	8	14	22
Koppal, District Hospital	0	1	1	0	0	0
Vijayanagara Institute of Medical Science (VIMS), Bellary	39	108	147	39	44	83
Raichur Institute of Medical Science (RIMS)	10	27	37	10	9	19

It is proposed to supply 1 C-PAP equipment to each of the 7 SNCUs in the HPDs as a pilot project .Koppal & Bagalkote hospitals have very few admissions as there has been no Pediatrician. Koppal has been up-graded to Medical College & 3 Pediatricians are working there from April. Baglakote is also being provided the services of a Pediatrician on contract. Hence the admissions in these centres is expected to rise in the coming months.

Justification:

Provision of C-PAP will help in better management of babies needing continuous positive pressure ventilation in breathing preterm neonates alleviating inadvertent use of High frequency ventilators.

C-PAP equipments available in the market being user-friendly can be operated by the Saff Nurses .

Deliverables :

Increase in survival of babies with RDS

Decrease in incidence of morbidities like Bronchpulmonary Dysplasia

Decrease in referrals of RDS cases from the SNCU

Decrease in morbidity & mortality resulting due to RDS

Proposal for purchase of Transcutaneous Bilirubinometer

Neonatal jaundice occurs in nearly 70% of term and 80% of preterm babies. Management of jaundiced neonates often requires measurement of total serum bilirubin (TSB). Total serum bilirubin (TSB) is commonly determined by spectrophotometric methods by analyzing plasma or serum sample. Such techniques require drawing of blood causing pain and trauma to the neonate. In addition, there is a wide range of intra- and inter-laboratory variability in the performance of the bilirubin analyzers. These problems have led to search for a non-invasive, reliable technique for estimation of TSB. A large number of studies have demonstrated the possibility of prediction of serum bilirubin in neonates by measuring the yellowness of the skin in the jaundiced neonate using transcutaneous bilirubino-meters.

Investigation for Babies admitted in SNCUs & NBSUs is not always done because of the cumbersome procedure involved both in drawing the blood & in the estimation. Provision of Transcutaneosbilirubinometers would enable immediate non invasive estimation and better management. It is proposed to provide Transcutaneosbilirubinometers to the 7 SNCUs in the HPDs as a pilot project.

No. of babies admitted for Jaundice in the SNCUs of High priority districts during 2013-14 is given below:

Name of SNCU	In Born	Out Born
Bijapur, District Hospital	45	5
Gadag, District Hospital	75	7
Bagalkote, District Hospital	45	1
Gulbarga, District Hospital	104	39
Koppal, District Hospital	42	0
Vijayanagara Institute of Medical Science (VIMS), Bellary	108	87
Raichur Institute of Medical Science (RIMS)	22	10
	441	149

Approximate cost per Common transcutaneous bilirubinometer available in the market is given below :

1. Airshield's-Minolta Hillrom-Airshield's Drager Medical Rs. 1,00,000/-
2. BiliTest Technomedialacteromedik Rs. 1,20,000/-
Pharmamen Enterprises
3. BiliCheck Spectrex Rustagi Surgicals,
Phoenix Rs. 1,75,000/-
4. Ohmeda Datex- Ohmeda Phoenix Not launched.

Reference – article @ www.newbornwhocc.org/pdf/tran.pdf

Cost of 7 Bilirubinometers @ an estimated cost of Rs. 1.5 lakh per bilirubinometer – Rs. 10.5 lakhs.

Justification :

It would alleviate repeated pricking & drawing of blood from neonates. Most of our laboratories do not perform Bilirubin estimation as it is cumbersome both to draw the blood & in estimating

Provision of Oxygen Generators

The Central Oxygen supply of hospitals have connections to the OT, SNCU, Dialysis unit etc. At times, preferential/excess use in the OTs result in exhaustion of supplies resulting in stock-out especially during the night. Individual Oxygen cylinders or Concentrators are used for the babies in the SNCUS during such times.

Oxygen Generators which convert & store Atmospheric Oxygen in tanks of 1000 litre capacity are available in the market. They can function with the regular electrical supply with 2KW UPS for back-up. Oxygen is available at a concentration of 93%.the equipment is safe to be placed in-doors .

One such equipment has been supplied to Gulbarga SNCU. It is proposed to supply 2 such equipments to each of the other 6 SNCUs of HPDs – Raichur, Bellary, Koppal, Bagalakote, Bijapur & Gadag.

Justification:

Provision of Oxygen Generators will help in decreasing stock-out of Oxygen .

Costs of refill & transport of cylinders is alleviated.

Deliverables :

Help in improvement of functioning & decrease problems faced in the hospitals during crisis.

Funding proposed :

Cost of 12 (2 for each SNCU) Oxygen Generators @ a cost of Rs.10 lakh per unit is estimated at Rs. 120 lakhs.

Provision of Solar Hybrid Generators

Uninterrupted electricity is a problem , especially in the rural areas. Hospitals have been fitted with Generators through KHSRRP. The problem faced in running these generators is the timely procurement of diesel & accountability for running & maintaining the generator.

Solar power is readily available especially in the northern districts of Karnataka which also comprise the HPDs. The hospitals being huge, there is ample space on the terrace to install solar generators.

It is proposed to install solar generators exclusively for the SNCUs as most life-saving equipments of SNCUs are run on electricity. These generators are of 3 KW capacity consisting of solar panels, battery, charge controller and other accessories costing about Rs. 3 lakh per system

It is proposed to supply 1 Solar Generator to each of the 7 SNCUs in HPDs (Gulbarga, Raichur, Bellary, Koppal, Bagalakote, Bijapur & Gadag) on a pilot basis during 2014-15.

Justification:

Provision of 24X7 electrical supply to the SNCUs

Low maintenance cost as the freely available solar energy is used.

Deliverables:

Continuous supply of power to SNCUs even during power cuts

Funding proposed :

Cost of 7 Solar Generators @ Rs. 3 lakh per unit is Rs. 21 lakhs

Proposal for establishment of a Centre of Excellence for Pediatric Surgery at Indira Gandhi Institute of Child Health

Indira Gandhi Institute of Child Health is an autonomous institute established by the Government of Karnataka. This premier non-profit organization offers multi-specialty services to children of low income groups. Patients are referred from all over Karnataka to this institution. The institute offers general, nephritic, genetic, surgical, endocrinology, Child Psychiatry & Rehabilitation Services. The institute is recognized as a centre for all the trainings under NRHM & is linked through tele-Medicine to some of the District Hospitals. There is a centre of excellence in Pediatric AIDS also which is closely associated with all NACO & KSAPS programmes.

There are 3 Operation Theatres in the Institute at present. Pediatric surgeries including general, gastro-enterology, ENT are being conducted in this hospital. About 1600 surgeries have been conducted in 2013 in the institute. Detailed Statistics is enclosed.

The Neonatal Intensive Care Unit has 30 beds. There have been about 1200 admissions during the last year and about 100 babies had to be referred for want of beds as most babies are very serious & would need admission for long periods. The Pediatric Intensive Care Unit has 36 beds which is also insufficient for the case-load. The surgical cases needing intensive care are also catered to in these ICUs.

The institute caters to cases of Aplastic Anemia, PIDs etc. which require Bone marrow transplant & other such specialized Surgeries including Cardiac, Renal, etc. It is proposed to establish 3 additional modular Operation Theatres and Neonatal and Pediatric intensive care units for the operated cases. The infrastructure costs will be borne out of state funds. Equipments for OT

&separate NICU and PICU to cater to the operated casesisestimated tocost Rs. 362.00lakhs. Details are given below.

Equipments for O.T. and Anaesthesia				
Sl. No	Name of the equipments	Qty Required	Approx. price for unit	Approximant cost (In Lakhs)
1.	Orthopedic Radiolucent Operation Table with attachments for Orthopedic & Spine surgeries.	1	7.5	7.5
2.	Basic Diathermy Units	3	5	15
3.	Shadowless OT Ceiling Lights (LED) with in-buiolt Camera with sterile Handle attachment	3	5	15
4.	Automated Operation Table with Remote control (C-Arm Compatible)	3	5	15
5.	Advanced Diathermy Units with Accessories	3	4	12
6.	Portable Ultrasound with Pediatric and Vascular probes (Anesthesia & Surgery)	1	15	15
7.	Ultrasonic Cutting & Coagulation device with temperature controlled Advance Bipolar Technology	1	15	15
8.	Fibre – optic Bronchoscope	1	6	6
9.	Pediatric Nephroscope	1	3	3
10.	Pediatric Ureteroscope	1	3	3
11.	Operative Magnifying Loupes	2	1.5	1.5
12.	Basic Surgical Instrument Set	6	0.5	3
13.	Hepatobiliary Surgical Instrument Set	2	1	1
14.	Pediatric Urology Instrument Set	3	1	1
15.	Vascular Surgical Instrument Set	1	1	1
16.	Orthopedic Instrument Set (Basic)	3	1	1
17.	Orthopedic Instrument Set (Advanced)	2	1	1
18.	Pediatric Resectoscope	1	4	4
	TOTAL			120

NEONATAL INTENSIVE CARE UNIT				
Sl. No.	Name of the Equipment	Units	Unit cost (In Lakhs)	Total cost (In Lakhs)
1	Open care System Radiant Warmer	20	0.75	15
2	Phototherapy unit	4	0.50	2
3	Neonatal Ventilator	5	12	60
4	Syringe Pump	20	0.30	18

5	Multisystem Monitor	10	6	60
6	Pulse oxymeter	10	0.3	5
7	ABG Analyser	1	15	15
8	Portable ultrasound with ECHO	1	15	15
Total				190

PEDIATRIC INTENSIVE CARE UNIT				
Sl. No.	Name of the Equipment	Units	Unit cost (In Lakhs)	Total (In Lakhs)
1	Multisystem Monitor	10	3	30
2	Infusion pumps	10	0.30	3
3	Syringe pumps	10	0.30	3
4	Pulse oximeter	10	0.3	3
5	ICU Cots	10	0.5	5
6	Dialysis Machine	1	8	8
Total				52

Justification:

Indira Gandhi Institute is proposed to be an identified tertiary center of excellence for Pediatric Surgery, new born care and Early Intervention Centre catering to referred cases from all over the state.

OT Statistics 2013

Sl. No.	Name of the disease	Total	Balasanjee vini	SC/ST	ESI	Yeshasvini
A	PAEDIATRIC UROLOGY					
1	PUJ Obstruction	35	6	3	1	3
2	Ureteric Reimplantation	31	3	3	0	1
3	P.U.Valve Ablation	23	2	3	0	1
4	ExtrophyEpisodicscompl e repair	16	1	3	0	1
5	Hypospadias Repair	81	6	9	6	1
6	Undescended Testis	65	6	2	3	0
7	Bladder Augmentation	14	0	3	2	1
B	NEONATAL SURGERY					
1	Oesophageal Atresia Repair	58	12	6	3	2
2	Congenital Diaphragmatic Hernia Repair	49	3	9	2	3
3	Intestinal Obstruction	63	15	6	4	2
C	TUMOUR SURGERY					
1	Abdominal Tumours Renal / Liver/	26	3	6	3	2

	RetropentonedTumour					
2	Chemoports	78	3	6	3	6
D	Laparoscopy / Thoracoscopy	106	45	30	25	6
E	HEPATOBIILIARY SURGERY					
1	Biliary Atresia	33	3	3	3	3
2	Choledochal Cyst	46	9	6	3	1
F	PAEDIATRIC NEUROSURGERY					
1	V.P.Shunt	78	15	18	12	9
2	NIMC	86	25	22	6	3
G	GASTRO INTESTINAL TRACT					
1	Anorectal Malformation Repair	99	6	12	3	3
Sl. No.	Name of the disease	Total	Balasanjee vini	SC/ST	ESI	Yeshasvi ni
2	Hirschsprung's Disease	104	18	12	6	3
H	GENERAL PAEDIATRIC SURGERY					
1	Circumcision	135	0	0	0	0
2	Hernia	170	0	0	0	0
3	Cyst/Sinuses	93	6	12	5	0
4	Bronchoscopy	80	6	9	5	0
	Total	1569	543	183	95	51

Innovations :

Facilities	No. of Units	Unit cost	Total recurring cost in Lakhs	Line item	Remarks
Establishment of centre of Excellence for Pediatric Surgery in Indira Gandhi Institute of Child Health, Bangalore	1	362	362	B14.4	Rs. 120 for OT Rs. 190 for NICU & Rs. 52 for PICU for post-surgical intensive care
Provision of Transcutaneous Bilirubinometer for SNCUs of HPDs	7	1.5	10.5	B16.1.2.3	To enable non-invasive estimation of Bilirubin in neonates
Provision of Baby Respirators to NBSUs in HPDs	46	1	46	B16.1.2.4	To provide user-friendly equipment for resuscitation of babies in NBSUs
Provision of C-PAP to SNCUs in HPDs	7	1	7	B16.1.2.5	To provide user-friendly equipment to provide continuous positive pressure ventilation to respiratory distressed babies
Provision of Oxygen Generators	12	10	120	B16.1.2.6	To provide uninterrupted supply of Oxygen to SNCUs of HPDs
Provision of Solar Generators	7	3	21	B16.1.2.7	For uninterrupted power supply to the 7SNCUs of HPDs

Nutrition Rehabilitation Centres (NRCs)

Nutrition Rehabilitation Centres (NRC) is a special unit located in a health facility and dedicated to the initial management and nutrition rehabilitation of childrens with severe acute malnutrition. These centres are preferably located at districts hospitals/ Medical college hospitals and will have 10-20 beds.

Under-nutrition is associated with high rates of mortality and morbidity due to common childhood illnesses including diarrhoea, acute respiratory infections, malaria and measles. To prevent deaths due to severe acute malnutrition (SAM), specialized treatment and preventive interventions are required.

In Karnataka there are 30 Nutrition Rehabilitation Centres at district level, 20 are attached to district hospitals and 10 are attached to medical colleges. They are either 20 or 10 bedded centres. They will have trained medical officer, staff nurses and diet counselors.

The staffing pattern is as follows:

1. Trained Medical Officer-1 per 10 beds and 2 per 20 beds
2. Staff Nurses (4 per 10 beds and 8 per 20 beds)
3. Diet Counselors (1 per 10 beds and 2 per 20 beds)
4. Cook cum care taker(1 per 10 beds and 2 per 20 beds)
5. Attender / cleaners- 2 for each centre.
6. Medical social worker- 1 for each centre.

Modified Nutrition Rehabilitation Centres (MNRC):

At FRU / Taluka level the facility based care units are referred as Modified Nutrition Rehabilitation Centre with 5-10 beds. There are 27 MNRC located at identified taluka level hospitals. These centres will have trained medical officers and staff nurses, Diet Counselors, cook, attendant and Social worker. The SAM children's referred from the community will be admitted in these centres for 14 days and treated as per the guidelines.

SAM Children are admitted into NRCs/MNRCs based on the criteria for admissions. Children and mother/care taker will stay for a maximum of 14 days. In addition to providing nutritious food to children, awareness is being created to mothers/care takers on preparation of nutritious food, hygiene & small family norms. An amount of Rs.100/- to compensate the loss of wages and Rs.50/- for food is being provided.

OBJECTIVES:

- To provide clinical management and reduce mortality among children with severe acute malnutrition, particularly among those with medical complications.
- To promote physical and psychosocial growth of children with severe acute malnutrition (SAM).

- To build the capacity of mothers and other care givers in appropriate feeding and caring practices for infants and young children.
- To identify the social factors that contributed to the child slipping into severe acute malnutrition.

SERVICES at NRC/MNRC:

- 24 hour care and monitoring of the child.
- Treatment of medical complications.
- Therapeutic feeding.
- Providing sensory stimulation and emotional care.
- Social assessment of the family to identify the contributing factors.
- Counseling on appropriate feeding, care and hygiene.
- Demonstration and practice by doing on the preparation of energy dense child foods using locally available, culturally acceptable and affordable food items.
- Follow up of children discharged from the facility .

Achievements upto December 2013 (NRCs/MNRCs)

Month	Admissions	Discharged with target weight gain	Referred (Medical Transfer)	Deaths	Children followed up
January to March	1005	576	27	17	602
April to June	1100	664	35	9	728
July to September	1297	895	36	10	902
October to December	1213	773	67	12	984

Justification:

Nutrition Rehabilitation Centre (NRC) is a special unit located in the district hospitals and dedicated to the initial management and nutrition rehabilitation of children with Severe Acute Malnutrition (SAM). In addition to curative care, special focus is given on timely, adequate and appropriate feeding for children. Inpatient management of Severe Acute Malnourished children is highly effective in reducing under 5 Mortality. Children suffering from under nutrition have increased susceptibility to infections, episodes of illness, which can be improved by referring and treating them at Nutrition Rehabilitation Centres. Without treatment of children who are affected by moderate or Severe Acute Malnutrition during the critical stage of life (i.e. first two years of childhood) it is difficult to achieve their full potential.

Deliverables:

Nutrition Rehabilitation Centres / Modified Nutrition Rehabilitation Centres are established to provide nutritious food along with medical treatment, thereby improving the health and nutritional status of severely malnourished children. Individual care is given and if health complications arise, it is immediately taken care by the trained medical officer / staff nurse and if necessary timely referral services are provided. Timely treatment with nutritious food supplements will definitely improve the overall health of the child. On the whole establishment of NRC's / MNRC's will prevent infant and child mortality to a great extent.

At present there are 30 NRCs are functioning at the district hospitals / Medical college hospitals and 27 MNRCs are functioning at the identified taluka level hospitals on the criteria of more number of SAM children's in that catchment area. It is proposed to continue the existing 30 NRCs and 27 MNRCs in the state and the budget is planned accordingly.

IEC materials related to nutrition programme is very essential for Vitamin 'A' supplementation programme, Measles linked Vitamin 'A' programme, Mass De-worming programme, ICDS services schemes, Importance of exclusive breast feeding and introduction of supplementary Nutrition immediately after six months is needed and also to educate parents/attenders in 57 NRC and MNRC's.

As per NREG wages it is Rs. 174/-per day. Hence to compensate the loss of wages same amount may be provided to the mother / care taker. At present Rs.50/- per day is provided for food to children it may be increased to Rs. 75/- per day.

Funding proposed for 32 NRCs

Rs. in lakhs					
Activity	No. of NRCs- 32	HPD	NON HPD	Amount	FMR code
		8	24		
Human resources	Medical Officer @ Rs.40000/- pm in HPDs and backward districts & Rs.35000/-pm in non - HPDs	6	14		A.8.1.5.6
	Budget	28.8	58.8	87.60	
	Staff Nurse @ Rs.14000/- pm in HPDs and backward districts & Rs.12000/-pm in non - HPDs	24	56		A.8.1.11.f
	Budget	40.32	80.64	120.96	
	Diet Counsellor @ Rs.10000/- pm	6	14		A.8.1.11.f
	Budget	7.2	16.8	24.00	
	Attender @ Rs.3500/- pm	6	14		A.8.1.11.f
	Budget	2.52	5.88	8.40	
	Cook @ Rs.5000/- pm	6	14		A.8.1.11.f
	Budget	3.6	8.4	12.00	
Beneficiaries	Estimated No. of beneficiaries for NRCs	2430	3550		
	of 32 NRCs -@ wage loss compensation for mother @ Rs.174/- per case per day totally for 14 days	59.1948	86.478	145.67	A.2.5
	Diet for mother & child @ Rs.125.00 per day totally for 14 days	42.525	62.125	104.65	
	Pharmacy supplies Rs.125.00 per day totally for 14 days	42.525	62.125	104.65	
Contingency	Contingency per facility @ Rs.1500 per month	1.08	2.52	3.60	
	Total budget for NRC	227.7648	383.768	611.53	

Funding proposed for 27 MNRCs

Rs. in lakhs

Activity	No.of MNRC	HPD	NON HPD	TOTAL	
		7	19		
Incentives	Incentive to 3 Staff Nurses of taluka hospitals for attending MNRC child	5.04	13.68	18.72	A.8.1.10.2
	Incentive to ICTC Counsellor for Counselling MNRC children	1.68	4.56	6.24	A.8.1.10.5
HR	Cook	4.20	11.40	15.60	A.8.1.11.f
Beneficiaries	No. of beneficiaries for MNRCs	570	840		
	Operating cost of 26 MNRCs -@ wage loss compensation for mother @ Rs.174/- per case per day	13.89	20.46	34.35	A.2.5
	Diet for mother & child @ Rs.125.00 per day totally for 14 days	9.98	14.70	24.68	
	Pharmacy supplies Rs.125.00 per day totally for 14 days	9.98	14.70	24.68	
Contingency	Contingency per facility @ Rs.1500 per month totally for 14 days	1.26	3.42	4.68	
Total budget for MNRC		46.02	82.92	128.94	

Total amount required for 30 NRCs	611.53
Total amount required for 27 MNRCs	128.94
GRAND TOTAL	740.47

NATIONAL IRON PLUS INITIATIVE

Calculation of beneficiaries for NATIONAL IRON PLUS INITIATIVE

0-5year children

age	total	rural	urban
0	933645	585530	348115
1	1017674	610927	406747
2	1010479	643739	366740
3	1042923	670442	372481
4	1041998	668857	373141
5	1087322	691487	395835
	6134041	3870982	2263059

Children accessible to government services

70% rural	2709687
20 % urban	452612
Total	3162299
50% will take complete treatment rounded to	1600000

Total 16 lakh

Add 10 % buffer – 1.6 lakh

Rounded to 18 lakhs IFA suspension

Albendazole

0-5 children		Albendazole	No. of tablets
6mths -1yr	140000	Nil	0
1-2 yrs	150000	1 tablet / child	150000
2-5 yrs	1300000	2 tablets per child	2600000
Total	1590000 (rounded to 1600000)		2750000 + 275000 buffer stock = 3025000 tablets

5-10 years children (13-14 DISE report SSA)

No. of children 5 – 10 years (out of school)	600000
No. of children 5 – 10 years (school going)	3000000
Total No. of children estimated	3600000

IFA

52 tablets / child for 36 lakh beneficiaries	187200000
10 % buffer (not kept s there are enough stocks in the schools	0
Total tablets required	187200000
No. of boxes of 100 tablets each	1872000
Cost of each box	Rs. 30
Cost of 1872000 boxes in lakhs	Rs.561.6

Albendazole

2 tablets / child for 36 lakh beneficiaries	7200000
10 % buffer (not kept s there are enough stocks in the schools	0
Total tablets required	7200000
No. of boxes of 100 tablets each	72000
Cost of each box	Rs. 119
Cost of 72000 boxes in lakhs	Rs.85

10-19 years (13-14 DISE report SSA)

No. of girls 10 – 19 years (out of school)	1000000
No. of children 10 – 19 years (school going)	3500000
No. of children covered (column 3+4)	4500000

IFA

52 tablets / child for 45 lakh beneficiaries	234000000
10 % buffer (not kept s there are enough stocks in the schools	0
Total tablets required	234000000
No. of boxes of 100 tablets each	2340000
Cost of each box	Rs. 30
Cost of 2340000boxes in lakhs	Rs.702

Albendazole

2 tablets / child for 45 lakh beneficiaries	9000000
10 % buffer (not kept s there are enough stocks in the schools	0
Total tablets required	9000000
No. of boxes of 100 tablets each	90000
Cost of each box	Rs. 119
Cost of 90000 boxes in lakhs	Rs.107

Women in reproductive age group

80% of rural - 6169183

30 % urban - 1610349

Total -7779532 rounded to 78 lakhs

Subtract 170000 pregnant & lactating women = 60 lakhs beneficiaries

52 tablets / woman for 60 lakh beneficiaries	312000000
10 % buffer	31200000
Total tablets required	343200000
No. of boxes of 100 tablets each	3432000
Cost of each box	Rs. 30
Cost of 3432000 boxes in lakhs	Rs. 1029.60

2 tablets / beneficiary for 60 lakh beneficiaries	1200000
10 % buffer (not kept s there are enough stocks in the schools	120000
Total tablets required	1320000
No. of boxes of 100 tablets each	13200
Cost of each box	119
Cost of 13200 boxes in lakhs	15.7

Pregnant & Lactating women

No. of Pregnant women – 1100000

No. of lactating women – 600000

Total – 170000

100 tablets / woman for 17 lakh beneficiaries	170000000
10 % buffer	17000000
Total tablets required(rounded)	180000000
No. of boxes of 100 tablets each	1800000
Cost of each box	Rs. 30
Cost of 18 lakh boxes in lakhs	Rs. 540

NUTRITION PROGRAMME

Vitamin 'A' Administration Programme:

This programme is implemented for pre-school children of 9 months to 5 years age are administered with concentrated Vitamin 'A' solution orally to prevent Night Blindness, formation of Bitot Spots and other Vitamin 'A' deficiencies leading to blindness. The Vitamin 'A' solution necessary for this programme is procured under NHM PIP line item no. B16.2.2.2

Two programmes are implemented under this viz.:

1. Measles linked Vitamin 'A' Programme:

One ml of Concentrated Vitamin 'A' solution containing 1 lakh IU is administered orally to the children of 9 months along with Measles Immunization. Around 11.42 lakh children are target beneficiaries of this programme. This is a routine monthly programme.

(ii) Vitamin 'A' supplementation programme:

This programme is implemented twice a year to the children of 1¹/₂ to 5 years. 2ml. of Concentrated Vitamin 'A' solution containing 2 lakh IU is administered to the children orally. Around 46.63 lakh children are target beneficiaries of this programme.

Achievement:

Sl. No.	Programme	Target	Achievement 2013-14	%
1	Measles linked Vitamin 'A' programme	1142638	855861	75
2	Vitamin 'A' Supplementation programme for 1 ¹ / ₂ to 5 years children (January-2014)	4248452	3947967	93
3	Mass D Worming Programme (January-2014)	4148018	3758789	90.6

2. Mass De-worming Programme for 1¹/₂ to 5 years children:

This programme was implemented for the first time in Karnataka for pre-school children of 1¹/₂ to 5 years age along with Vitamin 'A' Supplementation Programme from 15th to 30th September-2012. Albendazole tablets are distributed to pre-school children. 1¹/₂ tablet containing 200mg is given to children of 1 to 2 years. And 1 tablet containing 400mg is given to children of 2 to 5 years of age. Target beneficiaries are around 40 lakh children.

Justification:

Administration of Vitamin 'A' solution to pre-school children not only prevents blindness but it also improves immunity thereby reducing under 5 mortality rate. Vitamin 'A' is also essential for healthy skin.

Funding Proposed:

Sl. No	Activities	Target	Requirement	Unit Cost	Total Cost (Rs. in lakhs)	FMR Code	Remarks
1	Measles linked Vitamin 'A' Programme for 9 months children	12 lakh children 1ml each	12600 (100 ml each) bottles	Rs. 60 per bottle	7.56	B16.2.2.2	Including wastage
2	Vitamin 'A' supplementation programme for 11/2-5 yrs children (Biannual)	49 lakh children (for one round) For two rounds 98 lakhs (2ml each)	250000 (100 ml each) bottles	Rs. 60 per Bottle	150.00	B16.2.2.2	Including wastage
3	Albendazole tablets for Mass Deworming Programme	40 lakh children for 2 round 80 lakh children	1 tab 400mg/child 80 lakh tablets	Rs. 1.30 per Tablet	104.00		
	GRAND TOTAL				261.56		

A.3 Family Planning Programme in Karnataka:

Introduction:

Karnataka is the first state in the country to open up Government sponsored Family Planning Clinics in Bangalore and Mysore as early as in 1930 under the guidance of the then Maharaja of Mysore vide Gazette notification dated June 19, 1930.

A wide range of services are being provided at all facility levels across the state for promoting reproductive health and population stabilization.

Objectives:-

- To sustain the TFR achieved in the state
- To reduce the regional imbalances in the TFR focusing more on northern Karnataka
- To popularize the spacing methods more particularly PPIUCD to reduce the burden of medical complications associated with permanent methods and procedures and also the cost.
- Broader objective of the interventions would be empowering the couples to enjoy the reproductive health, improved maternal and child health status, and overall reduction in the malnourishment among the children and adolescents.

Strategies adopted:

1. Strengthening spacing methods including condom usage, oral pills and IUCD
2. Emphasis on Post partum family planning services more focus on PPIUCD
3. Capacitating the health care providers with hands on trainings to provide services including PPIUCD
4. Strengthening quality of services with regular quality assurance measures including supportive supervision and monitoring.
5. Providing of spacing tools at the doorsteps through ASHAs and grass root health functionaries.
6. Appropriate IEC and also counseling services through RMNCH counselors and other health care providers.
7. Popularising NSVs among men to encourage male participation and Gender equity.

Activities planned are narrated below with deliverables.

1. **Activity:** No Scalpel Vasectomy

It is a continued activity

This is an ongoing activity under Family Welfare programme. Due to multiple social and economic factors we are not able to achieve the success to the expected level. At the same time, we need to strengthen this activity considering the simplicity of the procedure and also encouraging gender equity and male participation in the family welfare programme. Along with this, this procedure does not require hospital stay or being away from the regular work. Hence regular NSV Camps are planned across the state at the facility level. It is expected to achieve a minimum of 4000 cases / beneficiaries during 2014-15 and phase by phase we would like to improve the male sterilization particularly NSV during 2015-16 and 2016-17 also.

Achievements:

FP Method	2010-11	2011-12	Achievement 2012-13	Achievement 2013-14 (Till December)
Male Sterilization	3214	3381	2716	1312

Package of Compensation in case of Vasectomy beneficiaries. Break up is as follows:

SI No	Particulars	Amount in Rs
1.	Acceptor	1100
2.	Motivator	200
3.	Drugs and dressings	100 (50+50)
4.	Surgeon's Charge	75
5.	Anesthetist	25
6.	Staff Nurse	15
7.	OT Technician	15
8.	Refreshment	10
9.	Camp Management	10
	TOTAL	1550

Justification: No scalpel vasectomy is a simple procedure with no complication and the procedure can be done at any facility upto PHC level. This activity has to be strengthened for the encouraging gender equity and male participation in the family welfare programme, hence this is activity is proposed for continuation.

Deliverables: Transport for service provider's team, DA as per entitlement of State Govt. norms, instruments, Sterilized dressing materials, gowns and linens, consumables like sutures and gloves, (procurement). It is proposed to deliver NSV services to 4000 beneficiaries for the year 2014-15.

Funding Proposed

Sl. No.	Description	No of Units	Cost per unit	Total Cost	FMR Code
1	Compensation for Male sterilization	4070	Rs.1,550/-	Rs.63,08500	A.3.1.4
2	Printing of Case Sheets and Sterilization Certificates	4070	Rs.50/-	Rs.2,03500	
			Total	Rs.65,12000	

2. Activity proposed : NSV Camps

It is a continued activity.

No scalpel vasectomy is done routinely in all the health facilities where ever ther family welfare camps are conducted. In order to improve the participation of males camp approach is adopted so that more male partners can be motivated for sterilization practices. It is proposed to have some expenditure to conduct the camps at the periphery.

Justification: No scalpel vasectomy is a relatively newer concept compare to female sterilization. As acceptance by male partner is poor. We need to motivate and convince the male partner in accepting the sterilization procedure. When they are in group they will be convinced about the simplicity of the procedure. In addition to the regular camps at the facility level we need to conduct mass camps in the districts.

Deliverables:

At least two mass camps per district with wide publicity in media etc.

Funding Proposed

					In lakhs
Sl. No.	Activity	No of Units	Cost per unit	Total Cost	FMR Code
1	NSV Camps	30 districts	0.30	9.00	A.3.1.2

3. Female sterilization:

It is a continued Activity

Female sterilization is a prominent activity under Family planning programme as well as a very important tool for promoting small family norms and thereby population stabilization. Though the thrust is being given to temporary methods in general and PPIUCD in particular female sterilization remains one of the popular method in Karnataka. Considering the advantages of one time intervention many prefer Female sterilization. The types of sterilizations provided in Karnataka are Minilap and Laparoscopic sterilizations. We have been popularizing postpartum sterilization also. The state is equipped with surgeons, OTs and other requirements to carry out this activity.

Achievements:

SL	Type of Sterilization	2011-12	2012-13	2013-14
1	Female	309285	258878	223312
2	Post Partum sterilization	64662	71557	52653
3	Male sterilization	3894	2857	1654
4	IUCD insertion	195487	189981	168030

Package of Compensation in case of Vasectomy beneficiaries. Break up is as follows:

SI No	Particulars	BPL	APL
1.	Acceptor	600	250
2.	Motivator	150	150
3.	Drugs and dressings	200 (100+100)	200 (100+100)
4.	Surgeon's Charge	75	75
5.	Anesthetist	25	25
6.	Staff Nurse	15	15
7.	OT Technician	15	15
8.	Refreshment	10	10
9.	Camp Management	10	10
	TOTAL (Rs)	1100	750

Justification: Majority of the female partners are accepting female sterilisation and also to promote the post-partum sterilisation this activity is proposed. The state is equipped with surgeons, OT and other equipments to deliver the quality female sterilisation service, hence this activity is proposed for continuation.

Deliverables: Both APL and BPL beneficiaries with compensation.

Funding Proposed

Sl. No.	Description	No of Units	Cost per unit	Total Cost in Rs in lakh	FMR Code
1	Compensation for Female sterilization				A.3.1.3
a	APL	70000	Rs.750	Rs.525.00	
b	BPL	180000	Rs.1100	Rs.1980.00	
2	Printing of Case Sheets and Sterilization Certificates	250000	Rs.50/-	Rs.125.00	
Total				Rs.2630.00	

4. Activity proposed : POL for Family Planning/ Others (including additional mobility support to surgeon's team if requested)

It is a continued activity.

The family welfare camps are conducted at identified 24*7 PHCs, CHCs, TLHs& DHs. A team consisting of surgeons, staff nurse & Group-d are trained to conduct the camps at out reached areas other than the DHs. These teams need vehicle and POL to attend the camps and also the concerned programme officers and other District level officers need POL for supervision and monitoring.

Justification: Family Planning sterilization involves lot of travels for providing services as well as monitoring the quality of services by supervisors/programme officers and also travels by surgeons, OT teams. Moreover transport is required to shift the emergency cases to the higher level. In Karnataka we have set up teams to conduct sterilizations both for male as well as female as per the requirements of a block. These identified teams would visit the facility and conduct the sterilization at Primary Health Centres and other hospitals where ever the OT is available. In other facility like District and Taluka Hospitals sterilization services are provided on a routine basis. Hence the POL is required for these mobile teams.

Funding Proposed

Sl. No.	Activity	No of Units	Cost per unit	Total Cost	FMR Code
1	POL	30 districts	Rs. 1.00	30.00	A.3.3

5. Activity proposed :

Repairs of Laparoscopes and Replacement of Spare Parts of Laparoscope

It is a continued activity.

Justification: In Karnataka we have been conducting Laparoscopic Sterilizations in a large scale. Approximately we have about 100 Laparoscopes in the state. Moreover procurement of about 50 Laparoscope is under the process. These Laparoscopes need repairs. Sometimes spare parts of these Laparoscopes needs to be replaced for providing quality services. Hence Repairs of Laparoscopes and Replacement of Spare Parts of Laparoscopes is proposed.

Funding Proposed			
No of Units	Cost per unit (in lakhs)	Total Cost (in lakhs)	FMR Code
30 districts	Rs. 1.00	30.00	A.3.4

6. Activity proposed: Family Welfare Workshops and Manuals printing

It is a continued activity.

Justification: Family Welfare is the base for both Maternal and Child Health Activities. The trends and the latest developments needs to be oriented to the programme officers. More over PPIUCD being the thrust area under the Family Welfare, we need to sensitize programme officers, Medical Fraternity including private practitioners. The cadres of service providers under Family Welfare methods include Surgeons, Medical Officers, Gynecologists, Nurses, Anesthetist, Counselors and Members of the OT team.

Justification: To sustain the population stabilization and to reduce the regional imbalances within the state we need to conduct workshop, sensitization, programmes etc on various aspects of programme planning, service delivery, quality assurance as well as integration with other activities within the department and other line departments. Hence a series of trainings, workshops etc are planned and the latest guidelines issued by GOI, manuals etc are supplied to the districts.

Deliverables: Workshops at districts to review the progress and to orient on standard guidelines, manuals etc.

Sl. No.	Activity	Funding Proposed		Total Cost (in lakhs)	FMR Code
		No of Units	Cost per unit (in lakhs)		
1	Workshops	30 districts	Rs. 0.50	15.00	A.3.2.5
2	Manuals & Guidelines printing	30 districts	Rs.0.25	7.50	A.3.2.5

7. Activity proposed: Review Meetings / QAC Meetings

It is a continued activity.

Justification: Supreme Court has directed to conduct the DQAC once in a month. This is done under the chairmanship of Deputy Commissioners and Facility Auditing is also done. This provides a forum to ensure the quality of services provided and also to rectify any deficiencies in the services. Hence this activity is proposed.

Deliverables: District Level Meetings and State Level Reviews

Funding Proposed		Total Cost (in lakhs)	FMR Code
No of Units	Cost per unit (in lakhs)		
30 districts + 2 State Level Meetings	Rs, 1.00 per district and Rs. 2.00 for state.	32.00	A.3.5.1

8. Activity proposed: WorldPopulation Day' observation at State, Districts and Taluka

It is a continued activity.

11th July is being observed as World Population Day. Every year as per the directions of GOI a series of activities are planned towards advocacy and awareness creation. State Level observations will provide a opportunity to showcase the political will power for population stabilization. In previous years honorable Chief Minister and Health Ministers have taken lead in the observations. Before the observation one fortnight is being observed as awareness fortnight and another fortnight is followed with intensive service providing campaign.

Justification: The main objective of the family welfare programme is population stabilization. In order to create awareness in the community 11th July is celebrated has world population day & on this day various activities are planned at state level, District level & Taluka level to sensitize the community about the population trends and impacts. Hence it is necessary to continue this activity.

Deliverables: One State Level Observation, 30 District Level Observations and 176 Taluka Level Observations.

Funding Proposed			
No of Units	Cost per unit (in lakhs)	Total Cost (in lakhs)	FMR Code
176 Taluka Level Observations	Rs. 10,000	1.76	A.3.5.4
30 District Level Observations and awareness fortnight at districts	Rs. 1.00	30.00	A.3.5.4
1 State Level Observation (including IEC activities, press advertisement, campaigns etc.	Rs. 30.00	30.00	A.3.5.4
GRAND TOTAL		61.76	

9. Activity proposed : Family Planning Indemnity Scheme

It is a continued activity.

Introduction:

Under the existing government scheme no compensation was payable for failure of sterilization and no indemnity cover was provided to doctors/health facilities providing professional services for conducting sterilization services. This created lot of problems especially doctors facing litigation due to claims of clients for compensation due to failure of sterilization. Hence this scheme was introduced to take care of the cases of failure of sterilization, medical complications or death resulting from sterilization and also provide indemnity cover to the doctors/health facilities performing sterilization procedures.

Budget will be released to Districts for Deaths, Failures & Complications following sterilization on case to case basis after receiving necessary documents from DQAC proceedings.

Justification: It is observed that after family planning sterilization deaths failures and complication are reported following sterilization operation. In order to provide services including treatment expenses indemnity scheme insurance coverage is made to the beneficiaries. Hence it is necessary to continue this activity.

Deliverables: Death claim will be Rs 2,00,000/- per case (Death within 7 days Rs 2,00,000/- and death between 8 to 30 days Rs.50,000/-). Failure claim will be Rs 30,000/- per client and Complications claim will be Rs. 25,000/-.

Funding Proposed			
No of Units	Cost per unit (in lakhs)	Total Cost (in lakhs)	FMR Code
	Death : Rs.50,000 to Rs. 2,00,000/- Failure : Rs. 30,000/-, Complication : Rs.25,000/-	Rs 65.00	A.3.6

10. Activity proposed: Appointment of RMNCH Counselors.

It is a continued activity.

Achievements: 32 Counselors are already recruited and functioning across the state.

Justification: Counseling is an integral part of quality FW Services. In the light of PPIUCD being the focus, counseling plays a critical role in the acceptance of the service. GOI has directed to have RMNCH Counselors in the facilities where substantial deliveries take place. Hence it is proposed to have 80 RMNCH Counselors in the state.

Deliverables: Recruitment of 40 counselors

Funding Proposed			
No of Units	Cost per unit (in lakhs)	Total Cost (in lakhs)	FMR Code
40 + 40 = 80	10,000/- per month x 12 months for 40counselors and for 6 months for 40 new ounselors	24.00	A.8.1.7.5.1

11. Equipments: Boyles Apparatus, Adult Ambu Bag and Oxygen Cylinder: New activity:

New operation theaters and few OTs require 100 Boyles Apparatus, 200 Adult Ambu Bags and 200 Oxygen Cylinders to meet any untoward emergencies. Hence it proposed to procure the same during 2014-15.

Total cost:

Drugs : for Sterilization cases: Existing available amount is not sufficient to provide all drugs to FP beneficiaries as the rates have been increased. It is proposed Rs.300.00 per beneficiary total cases would be 1.5 lakh beneficiaries. The drugs to be purchased are catgut, higher IV antibiotics, local anaesthetics, oral antibiotics, analgesics etc.

Total cost: Rs.450.00 lakhs

4 RASHTRIYA KISHOR SWASTHYA KARYAKRAM

Introduction:

Adolescents (10-19 years) constitute about one-fifth of India's population and young people (10-14 years) about one-third of the population. The large and increasing relative share and absolute numbers of adolescent and youth population in India make it necessary, that the nation ensure they become a vibrant, constructive force that can contribute to a sustainable and inclusive growth.

In order to enable adolescents fulfil their potential, substantial investments can be made in education, health, development and other areas. Investments in adolescents will have an immediate, direct and positive impact on India's health goals and on the achievement of the Millennium Development Goals (MDGs), especially goals 1,2,3,4,5 and 6; at the same time, it will enhance economic productivity, effective social functioning and overall population development. However, a considerable number of adolescents face challenges to their healthy development due to various factors, including structural poverty, social discrimination, negative social norms, inadequate education, and early marriage and child- bearing, especially in the marginalised and under- served sections of the population.

The approach proposed in the strategy is based on a continuum of care for adolescent health and development needs, including the provision of information, commodities and services at the community level, with mapped out referral linkages through the three-tier public health system.

In order to implement the programmes for adolescents 7 critical components has to be ensured across all the programme areas. These (7Cs) critical components are content, communities, clinic (health facilities), counselling, communication and convergence. The following six strategic priorities are emerged from the situation analysis of adolescent health they are nutrition, sexual and reproductive health(SRH), non-communicable diseases (NCDs), substance misuse, injuries and violence (including gender-based violence) and mental health.

A new adolescent health programme Rashtriya Kishor Swasthya Karyakram (RKSK) has been launched in January 2014. The programme envisages strengthening of the health system for effective communication, capacity building and monitoring and evaluation.

Objectives:

The main objective is to:

- Improve Nutrition
- Enable sexual and reproductive Health
- Enhance Mental Health
- Prevent injuries and violence (including Gender based violence {GBV})
- Prevent substance misuse
- Address conditions for NCDs

Strategies:

- Establishment of new "SNEHA" Clinics in all Medical Colleges of 8 High Priority Districts.
- Strengthening of existing "SNEHA" Clinics in all the health facilities of 8 High Priority Districts.
- Celebration Adolescent Health Day in selected villages of 8 High Priority Districts.
- Appointment of dedicated Adolescent Health Counsellors in "SNEHA" Clinics of Medical College Hospitals, District Hospitals, Taluka Hospitals and Community Health Centres of 8 High Priority Districts.
- Training & capacity building to Medical Officers, health supervisors, health workers, paramedical staff, staff nurses and dedicated Adolescent Health Counsellors / ICTC Counsellors & ASHAs of the 8 High Priority Districts.
- BCC/IEC activities in 8 High Priority Districts.

Activities:**A.4.1.1- Quarterly meetings / workshops / review for Adolescent Health (including Menstrual Hygiene Scheme)****It is a New Activity**

Regular quarterly meeting will be conducted at the state & district levels for all the 8 districts to review the implementation the programme.

Budget:

Sl. No	Activity	No. of units	Unit cost	Amount	FMR code	Remarks
1.	Quarterly review meeting at state level	3	0.50	1.50	A.4.1.1	Refreshment, Contingency & TA for contractual employees
2.	Quarterly review meeting at district level	24	0.50	12.00	A.4.1.1	Refreshment, Contingency & TA for contractual employees at 8 high priority districts
Total Budget required				13.50		

A.4.1.1.a - Organisation RKSK Regional Workshop

RKSK Regional Workshop will be organised in the state as per the directions of GoI. Hence it has been proposed in the budget

Budget proposed for regional workshop is Rs.10.00 lakhs

A.4.1.2 - Establishment of New "Sneha clinics" at DH/Medical college hospital level

The recently launched adolescent health strategy highlights the need for rolling out adolescent friendly health clinics (AFHC) across the State. The aim is to provide clinical and counselling services to adolescents through the existing health systems. With a slight physical make over, training of existing staff, introduction of counsellors and provision of commodities, existing facilities would be equipped to provide adolescent friendly health services.

AFHC services will be delivered through PHCs, CHCs, Taluk level hospitals, District Hospitals / District level hospitals and Medical College Hospitals.

The key "Friendly" component of AFHC mandates facility based clinical and counselling services for adolescents such that they are:

- Equitable
- Accessible
- Acceptable
- Appropriate and
- Effective

AFHCs will provide

- Support to Adolescent through interactions at times of concern/ crisis through counselling
- Provide referral with secondary and tertiary level facilities
- Make links with other services such as ICTC, deaddiction centres, ICDS counselling , District Early Intervention Centers (DEIC) and legal systems

Funding proposed:

Sl. no	Activity	No. of units	Unit cost	Amount	FMR code	Remarks
1.	Establishment of New clinics at Medical college Hospitals.	9	0.50	Rs. 4.50	A.4.1.2	09 Medical college Hospitals in 8 High Priority Districts @ Rs.50,000/- per Medical college Hospital for minor renovation, furniture, clinic signage, screens and examination table are procured.

A.4.1.4 - Operating expenses for existing clinics:

To implement this programme we propose to strength the existing SNEHA clinics in the 8 HPD.

Sl. No.	Activity	No. of units	Unit cost	Amount proposed	FMR code	Remarks
1.	Operating expenses for existing clinics:	556	0.05	27.80	A.4.1.4	556 clinics @ Rs.5000 for minor renovation, furniture, clinic signage, screens and examination table are procured.

A.8.1.7.5.2 - Adolescent Health Counsellors (Dedicated ARSH Counsellors):

It is a new activity.

Adolescent Health Counsellors role is critical for identifying and addressing the needs of an adolescent, so as to ensure.

- Provision of support
- Building of self esteem
- Resilience to set backs

The quality of counselling services will largely depend on the knowledge, attitude and skills of counsellors it is decided to have two (One Male & One Female) Dedicated Adolescent Health Counsellors at 8 High Priority Districts (HPD).

Sl. No.	Name of the District	DH	Medical college	CHC	TLH	Total
1	Bagalkote	1	1	8	5	15
2	Bijapur	1	2	9	4	16
3	Bellary	1	1	8	6	16
4	Yadgiri	1	0	5	2	8
5	Koppal	1	1	9	3	14
6	Raichur	1	1	6	4	12
7	Gulbarga	1	3	16	6	26
8	Gadag	1	0	2	4	7
	Total	8	9	63	34	114

Total no of Facilities = 114 X 2 Counsellors per Facilities (1 Male & 1 Female) = 228

Qualification:

- Age – 25 to 30 years (One Male & One Female) will be appointed.
- Masters in psychology/ social work.
- Capable of maintaining privacy/ confidentiality.
- Motivated to work for adolescent.
- Open, Compassionate, Sensitive willing to listen and engage young people
- Non-judgmental with a progressive attitude, in no circumstances should counsellor try to impose his/her values.
- Someone who demonstrates a clear understanding of laws, policies and procedures pertaining to informed consent and confidentiality, contraceptive services, abortion, STI/HIV testing and treatment, substance abuse treatment, management of mental health, sexual abuse, domestic violence .

A.4.1.5. Mobility Support to Adolescent Health Counsellors

To organise and conduct thrice a week out-reach activities for adolescents and parents in Schools/ Colleges and other platforms and to identify Peer Educators. Counsellors should also visit Sub-Canters on the day of Adolescent Friendly Clubs.

For the above works we are proposing Mobility support of Rs.1000/- per month per Adolescent Healthcounsellor.

Budget:**Funding proposed:**

Sl. No	Activity	No. of units	Unit cost	Amount	FMR code	Remarks
1.	HR					
	Salary for AH Counsellors	228	0.10	273.60	A.8.1.7.5.2	228 counsellors for 114 health facilities @ 10000/m/counsellor
	Mobility Support	228	0.01	27.36	A.4.1.5.	228 counsellors for 114 health facilities @ 1000/m/counsellor.

A.10.2.4. Dedicated Programme Assistant for RKSK**Need for close supervision and monitoring of the programme implementation:**

The programme needs close supervision and monitoring at district level in view of the vulnerable population (adolescents) involved. The success of the programme will be reflected in the future through improvement in 7c strategic

priorities. The Strategy identifies 7 critical components that need to be ensured across all the programme areas.

These Components are coverage, content, communities, clinics (Health Facilities), counselling, communication and converges.

In order to ensure the above in RKSK there is need for the close monitoring and supportive supervision for the effective programme implementation which can be achieved with a dedicated/committed programme assistant. Hence as explained above services of programme

assistant for RKSK is recommended who is a graduate with MPH/DPH/PGDHMM/MBA in HCS qualification is proposed to be hired on contract basis.

It is difficult for the RCHO who is the nodal officer for all RCH activities to conduct micro-level monitoring in all level of AFHCs or SNEHA clinics. A proper monitoring mechanism may be followed as mentioned bellow:

- Verification of functioning of SNEHA clinics by visiting Health facilities.
- Verification monitoring of supplies (SN Packs)
- Monitoring of RKSK related IEC materials etc.
- Ensure quality training at facilities as per training schedule.
- Ensuring proper referral made after health check-ups done and related follow-up.
- Prompt reporting of adverse effects & corrective actions.
- Ensuring timely submission of monthly and quarterly reports to State after verification of the same through RCHO.
- Organising quarterly review meetings and sharing the proceedings of the meetings with the State.

Remuneration/ Professional Fee:

His / Her professional fee Rs.25000/- per month with an increment of 5% of per annum after ascertaining successful/ satisfactory completion of work. The mobility support of Rs.2000 per month within the district.

Funding proposed:

Sl. No.	Particulars	No. of units	Unit Cost	Amount proposed	FMR code	Remarks
1.	Hiring HR: District RKSK Programme Assistant	08	0.25	18.00	A.10.2.4.	Rs.25000/m salary for 9 months
	Mobility support	08	0.02	1.44		TA / DA charges for 9 months
2.	Purchase of laptop	08	0.75	6.00		Laptop cost & MS office.
Total				25.44		

A.4.2.2 Organising Adolescent Health Day: (New Activity)

Adolescent Health Day (AHD) is the one of the strategies to achieve the objectives of adolescent health programme at community level. It seeks to

- Improve coverage with preventive and promotive interventions for adolescents.
- Increase awareness among adolescents, parents, families and stakeholders about the determinants of adolescent health.
- Improve awareness of other AH related services example AFHCs and help line.

AHD will be organised in select villages of 8 HPD every quarterly. The AHD will organised preferably on Sunday.

Target group – Adolescents both male and female in age group 10 to 19 years school going and school dropouts, married and unmarried and parents of adolescents.

Services:

- Information – IEC, IPC on nutrition, SRH, Mental Health, GVB, NCD and Substance Misuse.
- General Health check-up
- Referral to AFHC for counselling and clinical services, if required.

For the above activities we are proposing the Rs.2000/- per AHD X 1164 AHD in the select village in 8 HPD.

Funding proposed:

Sl. No.	Particulars	No. of units	Unit Cost	Amount proposed	FMR code	Remarks
1.	Adolescent health day celebration	456	0.02	9.12	A.4.2.2	Rs.2000 per AHD for refreshment and other contingency expenditure (228 AH counsellors will conduct the activity)
Total				9.12		

A.9.7.1.1 :- Training programme at SIHFW, Bangalore

District TOT for Adolescent Friendly Health Services training at SIHFW Bangalore.

It is proposed to conduct 4 Days training programme for Technical & Managerial Teams of RKSK. The team includes 8 RCHOs, 41 THOs & 24 DTC faculties. The training will conducted in 2 batches 30 each totally for 73 members. This is a TOT training.

4 Days TOT for Adolescent Friendly Health Services training for District officers

Sl. No	DTCs	Training Venue	District RCH Officer	Taluka Health Officer	DTC Persons	Total Persons	Extra	DA	TA	Refreshment	Contingency	No.of Batches (30 each)	Faculty	IOH	Budget
1	Bagalkote	SIHFW Bangalore	1	6	3	10	10	28000	30000	24000	10000	2	32000	14100	138100
2	Bijapur		1	5	3	9		25200	27000	10800	9000		0	6750	78750
3	Bellary		1	7	3	11		30800	33000	13200	11000		0	8250	96250
4	Yadgiri		1	3	3	7		19600	21000	8400	7000		0	5250	61250
5	Koppal		1	4	3	8		22400	24000	9600	8000		0	6000	70000
6	Raichur		1	5	3	9		25200	27000	10800	9000		0	6750	78750
7	Gulbarga		1	7	3	11		30800	33000	13200	11000		0	8250	96250
8	Gadag		1	5	3	9		25200	27000	10800	9000		0	6750	78750
		Total	8	42	24	74	10	207200	222000	100800	74000	2	32000	62100	698100.00

Note:-

1.DA:- Rs.700/- per person perday X 4 Days = Rs.2800/-

2.TA :- Rs 3000/- per person

3. Refreshment :- Rs.300 per person X 4 Days = Rs. 1200/- X 73 + 10 faculty = 83 members

4.Contingency :- Rs.250 per person X 4 Days = Rs.1000/-

5. Faculty :- Rs.1000/- per faculty X 4 faculty X 4 Days = Rs.16000/- per batch

6. IOH (Institutional Over Head) :- DA+ Refreshment + Contingency + Faculty * 15 / 100

Cost per batch of 30 members is Rs.3,49,050/-, total budget for training 2 batches is Rs.6,98,100/-.

5 Days TOT for Adolescent Friendly Health Services training for District officer

Sl. No	DTCs	Training Venue	District RCH Officer	DTC Persons	Total Persons	Extra	DA	TA	Refreshment	Contingency	No.of Batches (30 each)	Faculty	IOH	Budget
1	Bagalkote	SIHFW Bangalore	1	3	4	5	14000	12000	7504	5000	1	25000	7726	71230
2	Bijapur		1	3	4		14000	12000	6000	5000		0	3750	40750
3	Bellary		1	3	4		14000	12000	6000	5000		0	3750	40750
4	Yadgiri		1	3	4		14000	12000	6000	5000		0	3750	40750
5	Koppal		1	3	4		14000	12000	6000	5000		0	3750	40750
6	Raichur		1	3	4		14000	12000	6000	5000		0	3750	40750
7	Gulbarga		1	3	4		14000	12000	6000	5000		0	3750	40750
8	Gadag		1	3	4		14000	12000	6000	5000		0	3750	40750
		Total	8	24	32	5	112000	96000	49504	40000	1	25000	33976	356480

Note:-

1.DA:- Rs.700/- per person perday X 5 Days = Rs.3500/-

2.TA :- Rs 3000/- per person

3. Refreshment :- Rs.300 per person X 5 Days = Rs. 1500/- X 32 + 05 faculty = 37 members

4.Contingency :- Rs.250 per person X 5 Days = Rs.1250/-

5. Faculty :- Rs.1000/- per faculty X 5 faculty X 5 Days = Rs.25000/- per batch

6. IOH (Institutional Over Head) :- DA+ Refreshment + Contingency + Faculty * 15 / 100

Total Cost for district level officer training is Rs.3,56,480/-.

6 Days TOT for Adolescent Friendly Health Services training Counsellors

Sl. No	DTCs	Training Venue	District RCH Officer	DTC Persons	Total Persons	Extra	DA	TA	Refreshment	Contingency	No.of Batches (30 each)	Faculty	IOH	Budget
1	Bagalkote	SIHFW Bangalore	1	3	4	5	16800	12000	16200	6000	1	36000	11250	98250
2	Bijapur		1	3	4		16800	12000	7200	6000		0	4500	46500
3	Bellary		1	3	4		16800	12000	7200	6000		0	4500	46500
4	Yadgiri		1	3	4		16800	12000	7200	6000		0	4500	46500
5	Koppal		1	3	4		16800	12000	7200	6000		0	4500	46500
6	Raichur		1	3	4		16800	12000	7200	6000		0	4500	46500
7	Gulbarga		1	3	4		16800	12000	7200	6000		0	4500	46500
8	Gadag		1	3	4		16800	12000	7200	6000		0	4500	46500
		Total	8	24	32	5	134400	96000	66600	48000	1	36000	42750	423750.00

Note:-

1.DA:- Rs.700/- per person perday X 6 Days = Rs.4200/-

2.TA :- Rs 3000/- per person

3. Refreshment :- Rs.300 per person X 6 Days = Rs. 1800/- X 32 + 05 faculty = 37 members

4.Contingency :- Rs.250 per person X 6 Days = Rs.1500/-

5. Faculty :- Rs.1000/- per faculty X 6 faculty X 6 Days = Rs.36000/- per batch

6. IOH (Institutional Over Head) :- DA+ Refreshment + Contingency + Faculty * 15 / 100

Total Cost for district level officer training is Rs.4,23,750.

A.9.7.1.3 :- Training Programme at DTCs

4 Days Training to Medical officers who are working with AFHCs in PHC,CHC and taluka level. 4 Days Training on RKSK is proposed for 1158 members in 43 batches of 30 each.

4 Days TOT for Adolescent Friendly Health Services training												
Sl. No	DTCs	Training Venue DTCs	MO s	Extra	DA	TA	Refreshment	Contingency	No.of Batches (30 each)	Faculty	IOH	Budget
1	Baglkote	Bijapur	142	25	397600	284000	142000	142000	5	80000	114240	1159840
2	Bijapur	Bijapur	156	30	436800	312000	156000	156000	6	96000	126720	1283520
3	Bellary	Bellary	158	30	442400	316000	158000	158000	6	96000	128160	1298560
4	Yadgiri	Gulbarga	102	20	285600	204000	102000	102000	4	64000	83040	840640
5	Koppal	Raichur	124	25	347200	248000	124000	124000	5	80000	101280	1024480
6	Raichur	Raichur	142	25	397600	284000	142000	142000	5	80000	114240	1159840
7	Gulbarga	Gulbarga	226	40	632800	452000	226000	226000	8	128000	181920	1846720
8	Gadag	Dharwad	108	20	302400	216000	108000	108000	4	64000	87360	885760
		Total	1158	215	3242400	2316000	1158000	1158000	43	688000	936960	9499360
Note:-												
1.DA:- Rs.700/- per person perday X 4 Days = Rs.2800/-												
2.TA :- Rs 2000/- per person												
3. Refreshment :- Rs.250 per person X 4 Days = Rs. 1000/- X 2413 ANM/LHV + 425 faculty = 2838 members												
4.Contingency :- Rs.250 per person X 4 Days = Rs.1000/-												
5. Faculty :- Rs.1000/- per faculty X 4 faculty X 4 Days = Rs.16000/- per batch												
6. IOH (Institutional Over Head) :- DA+ Refreshment + Contingency + Faculty * 15 / 100												

Cost per batch Rs.2,20,916/- total budget for training 43 batches is Rs.94,99,360/-

5 Days Training to ANMs and LHVs. 5 Days Training on RKSK is proposed for 2413 members in 85 batches of 30 each (228 AH counsellors and 160 ICTC counsellors)

5 Days Training for Adolescent Friendly Health Services training														
SI · N o	DTCs	Trainin g Venue DTCs	AN M	LH V	Total Member s	Extra member s	DA	TA	Refreshme nt	Contingenc y	No.of Batche s (30 each)	Faculty	Miscell a neous	Budget
1	Bagalkote	Bijapur	284	39	323	55	484500	646000	472500	80750	11	269167	196038	2148954
2	Bijapur	Bijapur	320	42	362	65	543000	724000	533750	90500	13	325000	223838	2440088
3	Bellary	Bellary	343	45	388	65	582000	776000	566250	97000	13	325000	235538	2581788
4	Yadgiri	Gulbarga	180	27	207	35	310500	414000	302500	51750	7	172500	125588	1376838
5	Koppal	Raichur	187	24	211	40	316500	422000	313750	52750	8	200000	132450	1437450
6	Raichur	Raichur	237	42	279	50	418500	558000	411250	69750	10	250000	172425	1879925
7	Gulbarga	Gulbarga	366	58	424	75	636000	848000	623750	106000	15	375000	261113	2849863
8	Gadag	Dharwad	192	27	219	40	328500	438000	323750	54750	8	200000	136050	1481050
		Total	2109	304	2413	425	3619500	4826000	3547500	603250	85	2116666.67	1483038	16195954.17
Note:-														
1.DA:- Rs.300/- per person perday X 5 Days = Rs.1500/-														
2.TA :- Rs 2000/- per person														
3. Refreshment :- Rs.250 per person X 5 Days = Rs. 1250/- X 2413 ANM/LHV + 425 faculty = 2838 members														
4.Contingency :- Rs.250 per person X 5 Days = Rs.1250/-														
5. Faculty :- Rs.1000/- per faculty X 5 faculty X 5 Days = Rs.25000/- per batch														
6. IOH (Institutional Over Head) :- DA+ Refreshment + Contingency + Faculty * 15 / 100														

Cost per batch Rs.1,90,540.1/- total budget for training 80 batches is Rs.1,61,95,954.17/-

6 Days Training to Dedicated AH counsellors and ICTC counsellors. 6 Days Training on RSK is proposed for 388 members in 14 batches of 30 each (228 AH counsellors and 160 ICTC counsellors)

6 Days training for Dedicated ARSH Counselors for Sneha Clinics														
Sl. No	Name of district	DTC Name	Total no of ARSH Counselors	Total no of ICTC Counselors	Total	Extra members	DA	TA	Refreshment	Contingency	Total no of Batches (30 each)	Faculty	IOH	Budget
1	Bagalkote	Bijapur	30	20	50	10	90000	100000	90000	75000	2	72000	49050	476050
2	Bijapur	Bijapur	32	20	52	10	93600	104000	93000	78000	2	72000	50490	491090
3	Bellary	Bellary	32	20	52	10	93600	104000	93000	78000	2	72000	50490	491090
4	Yadgiri	Gulbarga	16	20	36	5	64800	72000	61500	54000	1	36000	32445	320745
5	Koppal	Raichur	28	20	48	10	86400	96000	87000	72000	2	72000	47610	461010
6	Raichur	Raichur	24	20	44	10	79200	88000	81000	66000	2	72000	44730	430930
7	Gulbarga	Gulbarga	52	20	72	15	129600	144000	130500	108000	3	108000	71415	691515
8	Gadag	Dharwad	14	20	34	5	61200	68000	58500	51000	1	36000	31005	305705
Total			228	160	388	75	698400	776000	694500	582000	15	540000	377235	3668135
Note:-														
1.DA:- Rs.300/- per person perday X 6 Days = Rs.1800/-														
2.TA :- Rs 2000/- per person														
3. Refreshment :- Rs.250 per person X 6 Days = Rs. 1500/- X 388 counsellors + 75 faculty = 463 members														
4.Contingency :- Rs.250 per person X 6 Days = Rs.1500/-														
5. Faculty :- Rs.1000/- per faculty X 6 faculty X 6 Days = Rs.36000/- per batch														
6. IOH (Institutional Over Head):- DA+ Refreshment + Contingency + Faculty * 15 / 100														

Cost per batch Rs.2,44,542/- total budget for training 15 batches is Rs.36,68,135/-

Funding proposed:

Sl. No.	Particulars	No. of units	Unit Cost	Amount proposed	FMR code	Remarks
1.	TOT training in SIHFW to District level TOT for MOs	2	3.45	6.9 (Not include in total)	A.9.7.1.1	Training cost includes refreshment charges, TA/DA for participants, course material & other contingency expenditure.
2.	TOT training in SIHFW to District level TOT for ANM/LHV	1	3.57	3.57 (Not include in total)		
3.	TOT training in SIHFW to District level TOT for Counsellors	1	4.24	4.24		
4.	Training of Medical officer in DTCs	43	2.21	95.03	A.9.7.1.3	
5.	Training of Counsellors DTCs	15	2.45	36.75		
6.	5 Days Training to ANMs and LHVs. DTCs	85	1.91	161.96	A.9.7.1.5	
Total				297.98		

A.10.2.4.b

As the RKSK is a new activity one State RKSK Nodal Officer is identified to implement this programme in the state. The state programme officer needs vehicle and other contingency expenditure to implement the programme in the state

Funding proposed

Sl. No.	Particulars	No. of units	Unit Cost	Amount proposed	FMR code	Remarks
1.	Laptop with accessories	1	1.00	1.00		Lap Top with accessories, (Multifunctional printer includes scanner, photo copying
2.	Office contingency	1	0.50	0.50		
3.	Vehicle hiring	1	0.30	3.60		Rs.30000 per month through outsourced agency.
Total				5.1		

B.10.3.4 - BCC/IEC activities for AH/Rashtriya Kishore Swasthya Karyakram:

In order to implement this programme in a more effective way and to ensure that this will reach the entire target group of Adolescents, an effective IEC strategy needs to be implemented.

The proposed program will be implemented in 8 districts during phase I and will be enhanced in further phases.

The proposed IEC is aimed to serve in the 8 districts ie., Bagalkote, Bijapur, Bellary, Yadgiri, Koppal, Gulbarga, Raichur, Gadag and hence the following budget is proposed to cover developing IEC materials such as Posters, Display boards, Flip books etc.,

This also includes developing and printing of resource materials.

Activity	Unit Cost	No of Units	Total Budget (in Lakhs)	Remaks
Operational Frame Work book	250	620	13.77	Total no of Books Required = 620 District office 3 books X 30 Districts = 90 Taluka office 3 books X 176 Taluka = 528 Extra Copies = 02
Training Module for ANMs and LHV's book	250	100		
Counsellors book	250	300		Total no of Dedicated ARSH counsellors in 8 District = 256 X Rs.250per book = Rs.1,51,500/-
Medical Officers book	250	600		Total no of DH = 18 + Tq H 146 + CHC 180 +PHC 2353 =2697 X Two Books per Hospital = 5394 + 606 Extra Copies = 6000 Books X Rs.250 = Rs.15,00,000/-
Total			13.77	

<i>Rashtriya Kishor Swasthya Karykram 2014 – 15</i>				
<i>FMR Code</i>	<i>Activities</i>	<i>Unit Cost (in . Rs/-)</i>	<i>Physical Target</i>	<i>Budget for 2014-15 (Rs.in lakhs)</i>
A.4.1.1	Quarterly meetings/workshops/review for AH (including MHS) At Stae level	50000	3	1.50
	At District Level	50000	24	12.00
A.4.1.1.a	RKSK Regional Workshop	1000000	1	10.00
A.4.1.2	Establishment of New clinincs at DH/Medical college level	50000	9	4.50
A.4.1.4	Operating expenses for existing clinics	5000	556	27.80
A.4.1.5	Mobility Support for AH/ICTC counselors	228000	228	27.36
A.4.1.6	Others (Please Specify) Priting of RKSK Books			
A.4.1.6.a	Operational Frame Work	250	620	13.77
A.4.1.6.b	Training Module for ANMs and LHVs	250	100	
A.4.1.6.c	Counsellors	250	300	
A.4.1.6.d	Medical Officers	250	600	
A.4.2	Community Level Services			
A.4.2.2	Organising Adolescent Health Day	2000	456	9.12
A.4.5	Other Strategies/Activities			
A.8.1.7.5.2	Adolescent Health Counselors (Dedicated ARSH Counselors)	2280000	228	273.60
A.9.7	Adolescent Health Training/ Rashtriya Kishor Swasthya Karyakram Training			
A.9.7.1.1	District TOT for Adolescent Friendly Health Services 6 training (Counsellors) in SIHFW	424000	1	4.24
A.9.7.1.3	Adolescent Friendly Health Services 4 days training for Medical Officers in DTCs	221000	43	95.03
	Adolescent Friendly Health Services 5 days training for ANM/LHV in DTCs	191000	85	161.96
	Adolescent Friendly Health Services 6 days training for Counsellors in DTCs	245000	15	36.75
Total Budget RKSK				677.63

A 5. Rashtriya BalSwasthya Karyakrama (RBSK)

Introduction:

Karnataka has initiated programmes for better neonatal survival through facility based (SNCU, NBSU, NBCC, PICU) & Home Based New born Care and Child services (HBNC, IMNCI) from 2007-08. The State has also been screening school going children and providing surgical interventions through "Suvarna Arogya Chaithanya" School Health Programme from 2006-07. Adolescents are being counselled and provided care through "**Sneha Clinics**" in all Public Health facilities from 2010-11. Adolescent girls have been provided Sanitary Napkins in Bagalkote, Belgaum, Bidar, Gulbarga, Mysore & Raichur, from 2011-12. Now the programme is being extended throughout the state as "**SUCHI YOJANE**", which is an initiative of GoK and is implemented from 2013-14. Malnourished children are identified through screening camps and provided nutritious food through Anganwadis. Severe Acute Malnourished children identified in these camps are treated in Nutrition Rehabilitation Centres of all District Hospitals and Modified Nutrition Rehabilitation Centres of selected 27 Taluka Hospitals from 2011-12. Detection and treatment of Retinopathy of Prematurity is an innovative Public Private Partnership Initiative of Karnataka and implemented from 2011.

Karnataka has implemented RBSK Rashtriya Bal Swasthya Karyakram (RBSK) programme from 2013-14 as Comprehensive child health care, which implies assurance of extensive health services for all children, from birth to 18 years of age, for a set of health conditions. These conditions are Diseases, Deficiencies, Disability and Developmental delays - 4 Ds. Universal screening would lead to early detection of medical conditions, timely intervention, ultimately leading to a reduction in mortality, morbidity and life-long disability. It is important to note that the 0-6 years age group will be specifically managed at DEIC (District early intervention centres) level while for 6-18 years age group, management of conditions will be done through existing public health facilities. DEIC will act as referral linkages for both the age groups.

First level of screening is to be done at all delivery points through existing Medical Officers, Staff Nurses and ANMs. After 48 hours of birth and till 6 weeks, the screening of new-borns will be done by ASHA, at home, as a part of HBNC package.

Outreach screening will be done by 402 dedicated mobile block level teams for the period of 6 weeks to 6 years at Anganwadi centres and for children in the age group of 6-18 years, at School. There are 176 blocks, each block has two teams (352 teams) another 50 teams for urban population.

Once the child is screened and referred, from any of these points of identification, it would be ensured that the necessary treatment/intervention is delivered at zero cost.

Once the child needs tertiary surgical care it would be ensured through empanelled Suvama Aroghya Suraksha Trust (SAST) & this scheme has now been extended to cover the following Medical disorders.

1. Congenital Hypothyroidism.
2. Metabolic & Chronic disorders in children.
3. GB syndrome.
4. RHD.
5. Reactive air way disease.
6. Haemoglobinopathies.

Objectives:

The main objective is to improve the quality of life of children through:-

- Early identification of birth defects and treating them.
- Identification of treatable metabolic (Ex. Hypothyroidism) and genetic disorders (Ex. Thalassemia) in children and providing necessary treatment.
- Identification & treatment of diseases like skin diseases, dental caries rheumatic heart diseases etc which are more common in children to prevent them to progress to more severe & debilitating form.
- To identify nutritional deficiencies and manage them both at the community and facility level
- To identify Developmental Delays and address them.

Strategies:

1. Fictionalization of RBSK teams
2. Establishment and operationalization of DEICs (District early intervention centres).
3. Public Private Partnership for Medical and Surgical interventions of the identified children.
4. Capacity building of RBSK & DEIC teams.
5. Inter-sectoral Co-ordination with WCD, Education, etc.
6. IEC/BCC Interventions.

Demographic profile:

Particulars	Estimated Numbers	Source
Population of Karnataka	6,10,95,297	Census 2011
0 to 19 years Population	2,06,84,000	Population Projections, Census of India
Children Enrolled in Schools (1 st to 10 th std)	1,00,62,083	Sarva Shiksha Abhiyana Report 2012-13
10 to 19 years Female (Adolescent girls)	53,15,000	Population Projections, Census of India
Adolescent girls enrolled in Schools	17,44,892	Suvarna Arogya Chithanya School Health Survey Report 2012-13
Out of School Adolescent Girls	13,79,851	Women and Child Welfare Department Report April -2013.
Children aged 0 to 6 years	71,61,033	Census 2011
Children enrolled in Anganwadi (0 to 6 years)	43,78,075	As per reports from nutrition section
New Born	11,30,905	Birth rate 18.5 per 1000 population (SRS Bulletins -2012)

1. Screening of Children

It is an on-going activity

Child screening under RBSK is at two levels -- community level and facility level.

- Facility based new born screening, at public health facilities like PHCs CHCs/TLHs/DH, will be done by existing health manpower.
- Community level screening will be conducted at Anganwadi centres and Schools by Mobile health teams. Each team has 2 Medical officers(1 Male & 1 Female), 1 Staff nurse and 1 ophthalmic assistant.

Screening at Community level:

a) Screening at Anganwadi Centre:

All pre-school children below 6 years of age will be screened by Mobile Block Health teams for deficiencies, diseases, developmental delays including disability at the Anganwadi centre at least twice a year. The tool for screening for 0-6 years is supported by pictorial, job aids specifically for developmental delays. For developmental delays children screened using age specific and tools specific parameters. The suspected Children will be referred to DEIC for further management.

b) Screening at Schools-Government and Government aided:

School children aged 6 to 18 years Will be screened by Mobile Health teams for Deficiencies, diseases, developmental delays including disability, adolescent health

at the local schools at least once a year. The tool used is questionnaire and clinical examination.

The team sends the report in the prescribed format every month to the District programme management officer through concerned taluk health officers.

Supportive supervision:

Supportive supervision by State level officer;

RBSK is a new initiative aimed at screening over 1.4 crore children from 0-18 years for **4Ds –Defects at birth, Diseases, Deficiencies & Developmental Delays including Disabilities.**

- The task is gigantic starting from simple screening by ASHAs till surgeries at tertiary level, which needs continuous monitoring & supportive supervision by State/District level officers. To roll out the programme effectively the State nodal officer needs to monitor at different levels.
- Supportive supervision also focused to monitor the functioning of DEICs while and after the establishment.

Achievement

In the year 2012-13 under Suvarna Arogya Chaitanya programme

- Total No. of children examined- 8485516
- No. of children treated for minor ailments -986309
- 1219 surgical interventions were undertaken at Yeshasvini Network Hospitals for Tertiary Care.

As per RBSK guidelines process initiated to functionalised screening by dedicated mobile health teams at taluka level in all the 176 talukas (2team per talukas) and also urban area for 50 teams. It is proposed to continue the Suvarna Arogya Chaitnya school health programme as RBSK (Rashtriya Bal Swasthya Karyakrama) for screening of all children between 6 to 16 years (1st to 10th std) at schools and 0 to 6 years at Anganwadi centres by dedicated mobile health teams. The school health programme has subsumed under RBSK.

No. of schools (1st to 10th std) & Anganawadi centers covered:-

Government Schools	Aided Schools	Un-aided Schools	Residential Schools	No. of Anganawadi Centres
50381	10341	9481	1828	60447

Justification

Out of every 100 babies born in this country, annually, 6 to 7 have a birth defect. It is estimated that about 72717 babies may be born with birth defects & about 716103 children (0-6yrs) may have developmental delay. Around 1,80,000 children may have developmental disability. Developmental delays are common in early childhood affecting at least 10 percent of the children. These delays, if not intervened timely, may lead to permanent disabilities including cognitive, hearing or vision impairment. Nutritional deficiencies affecting the pre-school children range from 4% to 70%. Also there are a group of diseases common in children viz. dental caries, rheumatic heart disease, reactive airways diseases etc. Early detection and management of diseases including, deficiencies bring added value in preventing these conditions, to progress to their more severe and debilitating form and thereby reducing hospitalization and improving implementation of Right to Education.

Deliverables:

Child Health Screening and Early Intervention Services under RBSK envisages to cover 30 selected health conditions for screening, early detection and free management. It is expected to cover 1,55,71,063 children, i.e. 25% of Karnataka population (0-16 years). Early detection and management can help a child to lead near normal life.

Funding proposed:

Rs. In lakhs

Sl. No.	Activity	No. of units	Unit cost	Total Cost	FMR code	Remarks
1	HR					
	MOs – 1. MBBS 2. AYUSH (BAMS)	186 618	0.60 0.28	1339.20 2076.48	A.8.1. 7.4.1	186 MBBS doctors Rs.60000 pm X 12 months = Rs.13,39,20,000/- 618 AYUSH (BAMS) doctors Rs.28000/m X 12 months = Rs.20,76,48,000/- Total Budget is Rs.34,15,68,000/-
	Total :-			3415.68		
	Staff Nurse	92 310	0.14 0.12	154.56 446.40	A.8.1. 7.4.2	92 SNs in HPD Rs.14000 pm X 12 months = Rs.1,54,56,000/- 310 SNs in non HPD Rs.12000/m X 12 months = Rs.4,46,40,000/- Total Budget is Rs.6,00,96,000/-
	Total :-			404.16		
	Ophthalmic Assistant	402	0.10	482.40	A.8.1. 7.4.3	Rs. 10000/m/ophthalmic assistant for 9 months
	Data Entry Operator	30	0.15	54.00	A.10.1 .8	Rs.12000/m /DEO
2	Hiring of vehicle	402	0.30	1447.20	A.5.1. 3	Rs.30000/m per vehicle
3	Miscellaneous & contingency	402	0.05	20.10	A.5.1. 6	Rs.5000 per year per team & for district level office

4	Contingency & stationary expenditure for State programme officer	1	5.0	5.0	A.5.1.7	
5	Quarterly convergence Meetings				A.5.1.9	Department of education, ICDS, PRI, water & sanitation & empowerment as convergence meeting at State, District & Taluk and review meetings
	At State Level	2	0.10	0.20		
	At District Level	60	0.04	2.40		
	At Taluka Level	352	0.035	14.00		
	Total:		16.60			
6	Essential Drug Kit for mobile team	402	0.80	321.16	B.16.2.7.1	EDL proposed as per RBSK guidelines Rs.8000 X 10 rounds = Rs.80,000/- X 402 teams = Rs.321.16 /-
7	Printing of RBSK Screening tool cum referral card for children 0 to 6 years	4378075	0.0001	437.80	B.10.7.4.3	Total no of Children at AWC 4378075 X Rs.10 per tool = Rs.4,37,80,750/-
8	Printing of RBSK Screening tool cum referral card for children 6 to 16 years	5031042	0.0001	503.10	B.10.7.4.3	Total no of School Children (6 to 16 years) 10062083, 50% of the students are calculated for cards the total cards required 5031042 X Rs.10 per tool = Rs.5,03,10,420/-
9	3 days training to all MOs of delivery points	33	1.65	54.33		Total no of MOs 1000. Total no of batches 33 X Rs.1,64,650/- per batch = Rs.54,33,450/-
	3 days training to all SNs at delivery points	66	1.65	108.67		Total no of 2000 Staff nurse. Total no of batches 66 X Rs.1,64,650/- per batch = Rs.1,08,66,900/-
10	Prepare & disseminate guidelines for RBSH	4000	0.001	4.00	A.4.2.1	Total 4000 copies of RBSK guideline @ Rs.100 per book & to be distributed to WCD, Education & Health Dept to encourage co-ordination.
11	Mobile Health Team Register for Anganawadi Centres	804	0.005	4.02		Total No of SH Teams X 2 register = 804 X Rs.500/- per register = Rs.4,02,000/-
12	Mobile Health Team Register for Schools	804	0.005	4.02		Total No of SH Teams X 2 register = 804 X Rs.500/- per register = Rs.4,02,000/-
13	Delivery Point Register	1000	0.005	5.00		Approximate no of Delivery Points = 1000 X Rs.500/- per register = Rs.5,00,000/-

14	Incentive to ASHA	27468 infants with birth defects, 430000 children (0-6yrs) with developmental delay, 60% of 457468 is 274000	100/case X 274000	274.00		64.3 infants per1000 live birth are born annually with birth defects (HMIS: 829191 live births & IMR is 32/1000 live births) 27468 children may have birth defects . 430000 children(0-6yrs) may have developmental delay (source 43 lakhs AWC children - 10% of children<6yrs have developmental delay) ASHAs will cover 60% of the population i.e rural population
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2. District Early Intervention Centres (DEIC) :-

It is an on-going activity

Rashtriya BalSwasthya Karyakram (RBSK) is a screening program aiming at early identification and early intervention for children, from birth to 18 years. It is important to note that the 0-6 years age group will be specifically managed at DEIC level while for 6-18 years age group, management of conditions will be done through existing public health facilities. DEIC will act as referral linkages for both the age groups

Approval has been obtained for establishment of 6 DEICs in Medical College Hospitals of Bangalore, Mysore, Bellary & Dharwad (Hubli) and District hospitals of Dakshina Kannada & Gulbarga in supplementary PIP 2013-14. Process for establishment of same has been initiated and will be continued during this FY. Children referred from schools and Anganwadis are being taken care of in these centres.

Achievement:

Gap analysis regarding resources like infrastructure, HR, etc is under process. Process for procurement of OAE (Oto acoustic emission) equipment is initiated.

The following 6 centres are the nodal centres to cater to the children identified and referred by RBSK teams and health facilities of the catchment districts.

Name of the DEIC	District where situated	Catchment Districts
Indira Gandhi Institute of Child Health / Vani Vilas Hospital	Bangalore	Bangalore,Ramanagar, Tumkur,Kolar,Chikballapur

Regional Advance Peadatric Care Center Wenlock Hospital (District Hospital Dhakshina Kannada)	Mangalore	DK,Chikkmagalore,Udupi, Hassan,Shimoga
Vijayanagar Institute of Medical Sciences	Bellary	Bellary, Chitrdurga, Raichur, Koppal
Karnataka Institute of Medical Sciences	Hubli	Bagalkote, Dharwad, Belgaum, Gadag, Haveri , Davanagere, UK
Chaluvamba Hospital	Mysore	Mysore, Mandya, Chamarajnagar, Kodagu
District Hospital/ESI Medical College	Gulbraga	Gulbarga, Bijapur, Bidar, Yadgiri

Justification:

Providing referral services to children referred for conformation of diagnosis and treatment. All children who are referred are screened at the "District Early Intervention Centre". All new-borns delivered at the District Hospital, including those admitted in SNCU, postnatal and children wards are screened for their sickness of hearing, vision, congenital heart disease. The screening will be done before the discharge.

Every child born sick or preterm or with low birth weight or any birth defect is followed up at the District Early Intervention Centre. All the referrals for developmental delay are followed and records maintained.

The Lab Technician of the DEIC would screen the children for inborn error of metabolism and other disorders, at the District level depending upon the logistics and local epidemiological situations. DEICs acts as linkage with tertiary care facilities through agreed MOU.

Deliverables:

All the new born babies, and referred childrens from schools and Anganwadi centres and also from other sectors are managed at the established DEIC.

Funding proposed:

Sl. No.	Particulars	No. of units	Unit cost	Total Cost	FMR code	Remarks
	HR					
	DEIC Manager	6	0.15	8.10	A.8.1.7.4.4	Total no of DEIC managers 6 X Rs.15,000/- = Rs.90,000/- X 9 months = Rs.8,10,000/-
	Infrastructure	6	25.00	150.00	B5.13.1	
	Equipments					
	OAE Equipments	6	3.00	18.00	B16.1.6.3.2	
	Recurring expenditure	6	0.20	1.20	A.5.1.4	Total no of DEICs 6 @ Rs.20,000/- per annum
Total :-				174.60		

A.5.2 Referral Services:

This is an on-going activity

Management of Children referred from Schools & Anganwadis:-

Children referred from schools requiring tertiary surgical care are treated at Suvarna Aroghya Suraksha Trust network Hospitals, both public and private. Children needing medical care will be treated at the government health facilities and DEICs. 0 to 6 years children registered in anganwadis and possessing BPL card are treated for severe infections and chronic illnesses in 20 identified Hospitals under the Bala Sanjeevini Scheme of the Women and Child Development Department of the State Government.

Achievements:

The details of surgical intervention done at Yeshasvini Network Hospitals under NRHM:

Year	Surgeries done	Expenditure
2008-09	1537	7,19,86,961
2009-10	2072	10,54,12,765
2010-11	2538	7,78,53,291
2011-12	1241	6,30,42,055
2012-13	1219	7,03,71,908
2013-14 (Up to Dec 2013)	1151	6,13,96,599

Surgical intervention done so far is 1151 and the expenditure is Rs.6,13,96,599 through Yeshasvini Network Hospital for Tertiary Care up to 03-12-2013. We need to continue this programme further for 2014-15.

Justification:

Many physical defects, if detected early, can be treated with surgery, including cleft lip or palate, and certain heart defects. About 50 percent of babies with Down syndrome have a congenital heart defect. Some defects are minor and may be treated with medications, while others may require surgery. Club foot is a congenital deformity, if not treated at an early stage, this deformity can lead to life time disability. In case of children with congenital cataract, permanent loss of vision (amblyopia) may occur, if prompt treatment is not provided

Funding proposed Surgeries

Disease	Estimated Number	Estimated Beneficiaries	Estimated Cost in Lakhs
Heart Disease in 0-6 age group	3488 @ 3.9/1000 live births	872 (25% of Estimated) rounded to 1000	Rs.500.00 (@ Rs.50000 per case)
Heart Disease in older children	1000	1000 Based on no of surgeries for school children over the last 5 years.	Rs.500.00 (@ Rs.50000 per case)
Orthopaedic Disease	3577 CDH @4/1000 live births	894 (25% of Estimated) rounded to 500	Rs.150.00 (@ Rs.30,000/- per case)
Neural Tube Defect	3577 @4-8/1000 live births	393 (11% of Neural Tube Defect are Meningomyelocoele) rounded to 133	Rs.20.00 (@ Rs.15,000/- per case).
Eye defects other than ROP	7500 @4.8% of SNCUs babies screened	1500 (1% of babies screened need treatment) 50 babies	Rs.2.50/ (-Rs.5000/- per case)
Cleft lip/ Cleft palate	800 @1/1000 live births	400 (50% of Estimated)	Rs.80.00 (@ Rs.20,000 /- per case)
Total			Rs.1252.50 lakhs

Funding proposed medical treatment for chronic disorders in children

Disease	Estimated Number	Estimated Beneficiaries	Unit Cost per year	Estimated Cost in Lakhs
Sickle Cell Anaemia	5-34% in tribal groups	38	Rs. 30000/-	11.40
Beta Thalassemia	3-4% in some areas	120	Rs.30000/-	36.00
Total				47.40

Total Estimated Budget for Referral Services is Rs.1300.00 lakhs

WIFS

Weekly Iron & Folic acid supplementation program (WIFS) Programme for Adolescents Girls and Boys (10-19yrs)

Introduction:

Adolescents are the most vulnerable group among the children for Iron deficiency anaemia. During adolescence age, especially for girls, Iron deficiency anaemia results into growth deficiencies. During adolescence, iron deficiency anaemia can result in impaired physical growth, poor cognitive development, reduced physical fitness and work performance and lower concentration on daily tasks. Iron deficiency in adolescent girls influences the entire life cycle.

In order to develop evidence based intervention for prevention and control of adolescent anaemia in India, various studies were commissioned. Findings across these studies reveal that weekly supplementation of 100mg Iron and 500µg Folic acid is effective in decreasing prevalence of anaemia. As adolescent anaemia is a critical public health problem in the country, the Ministry of Health and Family Welfare, Government of India, based on the empirical evidence generated by these scientific studies, has developed Operational Framework for Weekly Iron and Folic Acid Supplementation (WIFS) of adolescent.

Objective:

- To reduce the prevalence and severity of nutritional anaemia in adolescent population in the age group 10-19 years.

Strategies:

1. **Administration** of Weekly Iron and Folic Acid Supplementation (WIFS). Each IFA tablet containing 100mg elemental iron and 500µg folic acid for 52 weeks in a year.

2. **Screening** of target groups for moderate/severe anaemia and referring these cases to an appropriate health facility.
3. **Biannual de-worming** (Albendazole 400mg), six months apart, for control of worm infestation.

Activities:

1. Procurement of IFA tablets and Albendazole

- a. **IFA:** (4944839* 52 weeks* Rs.30 for 100 tab 5.5% vat, 1% handling charges)

No. of units - 2863139 X Cost Rs.30 = **Rs.914.78 lakhs.**

- a. **Albendazole:** (4944839* 2 dose in year* Rs.30 for 100 tab 5.5% vat, 1% handling charges)

No. of units – 110121 X Cost Rs.119 = **Rs.204.42 lakhs.**

2. Supplementation of IFA tablets and Albendazole

- a. Supplementation of IFA tablets and Albendazole at Schools for School going children of 6th to 10th Standard for Boys and Girls.
- b. Supplementation of IFA tablets and Albendazole at AWCs for non-school going Girls only (10 to 19 years)

3. Supervision & Monitoring at Various levels.

4. Inter-sectoral convergence.

5. Coverage evaluation study.

6. IEC/BCC awareness.

Achievement:

Activity	Achievements
School going children of 6 th to 10 th Standard for Boys and Girls & Out of school adolescent girls.	Est. Population- 4944839 Target achieved- 4616188 (93.35%)

Deliverables:

Supplementation of 100 mg of elemental iron & 500 micro grams of folic acid for schools and for out-of-school adolescent girls at AWC.

- Timely distribution of IFA/Albendazole tablets
- Printing and supply of relevant IEC material and activities

- Convergence and quarterly review meetings at State, district and talukas
- Routine monitoring of programme by the MOs, THOs and District & state level program officers.

Funding proposed:

Coverage assessment study for the implementation of WIFS:

In order to assess the impact of the coverage of WIFS, a coverage assessment study need to be done by identifying a recognised institution.

An amount of Rs.5 lakhs is proposed for the above task. The study results will be useful to implement further for the year 2014-15. The findings of the study will be shared with the districts and the same will be adopted while implementing the programme.

Convergence meetings at State level :

There is a need to improve the reporting system at PHC, Taluka & at District level. In order to improve the above a convergence between department of Health & WCD is needed. Hence, convergence meetings at State level & District level are proposed.

Quarterly meetings at state level are proposed @ Rs.10000/- per meeting with a total budget of Rs.40,000/-.

convergence meetings at district level are proposed @ Rs.5,000/- per meeting with a budget of Rs.10,000/- for 30 districts with a total budget of Rs.3,00,000/-

WIFS Campaigns at Block level to promote awareness on Nutritional Anaemia:

There is a need to improve the awareness level on Iron Deficiency Anaemia at Block and PHC & Village level. Hence awareness programmes at Taluka level have been proposed for 176 taluks @ Rs.10,000/- per taluka with a total budget of Rs.17,60,000/-.

Awareness for elected representative (ZP and TP members):

Since the programme is launched from July 2013, many elected representatives are yet to understand the entire programme and its strategies for implementation. In order to make them responsible in the successful implementation of the programme, there is a need to create awareness among elected representatives of Zilla Panchayat and Taluka Panchayat. Hence about 30 District level awareness programmes have been proposed @ Rs.10,000/- per programme with a total budget of Rs.3,00,000/-.

WIFS Annexures to each institute (43000 schools and 63000 AWCs):

Since there is no uniform reporting system is followed in the schools and anganawadi centres. Hence there is a necessity to supply proper reporting formats required at each institute. Therefore about 5 formats to each institute is proposed to supply.

An estimated budget of Rs.6,80,000/- is proposed for 72,000 schools & 64,000 anganawadi centres @ Rs.5/- per 5 copies of Annexures (Reporting formats).

**Proposed budget for WIFS (NATIONAL IRON PLUS INITIATIVE)&
Albendazole – Age group (10-19) years (2014-15):Rs. In lakhs**

Sl. No.	Particulars	No. of units	Unit cost	Total Cost	FMR code	Remarks
1.	IFA tablets VAT 5.5%Handling Charges 1%	2863139	0.0003	858.95	B.16.2.6	Total no of IFS tab box required 2863139 @ Rs.30 per box = Rs.8594170 X 5.5 % VAT =Rs.4724179.35 and 1% Handling charges = Rs.858941.7 The total budget is Rs.914.78
2.	Albendazole tablets VAT 5.5%Handling Charges 1%	110121	0.00119	131.05	B.16.2.6	Total no of Albendazole tab box required 110121 @ Rs.119 per box = Rs.13104399 X 5.5 % VAT = Rs.7207420 and 1% Handling charges = Rs.131044 The total budget is Rs.204.42
3.	Convergence meetings at State level	4	0.10	0.40	A.2.12	4 Quarterly at state level @ Rs.10000/- per meeting X 4 meetings = Rs.40,000/-
4.	Convergence meetings at District level 2 times in a district	2	0.05	3.0	A.2.12	2 convergence meetings at district level X Rs.5,000/- per meeting = Rs.10,000/- X 30 districts = Rs.3,00,000/- total budget for meeting.
5.	WIFS Campaigns at Block level to promote awareness on Nutritional Anaemia	176	0.10	17.60	A.2.12	Total no of taluka 176 X Rs.10,000/- per campaign = total budget is Rs.17,60,000/-
6.	WIFS Annexures to each institute (43000 schools and 63000 AWCs)	1.36	0.00005	6.80	B.10.7.2	Total no of schools = 72,000 + total no of AWC = 64,000 = 1,36,000 X Rs.5 per set of 5 annexures = Total budget is Rs.6,80,000/-
Total :-				1017.80		

**National Iron plus Initiatives (NATIONAL IRON PLUS INITIATIVE):
Supplementation of Iron and Folic acid tablets for Children 5-10 years (61 months onwards)**

It is a new activity.

Introduction:

Iron deficiency during childhood is often caused by inadequate dietary intake, lack of absorption or utilisation of iron, increased iron requirements during the growth period, or blood loss due to parasitic infections such as malaria and soil-transmitted worm infestations.

The following intervention is proposed for this age group.

Dose and Regime

Tablets containing 45 mg of elemental iron and 400 mcg of folic acid will be given once a week throughout the 5–10 years period. In addition to IFA supplements, Albendazole (400 mg) tablets for de-worming will be administered twice a year for anti-helminthic treatment.

Implementation:

The platform of school and AWC would be utilised to provide IFA supplementation and de-worming tablets to children in the age group 5–10 years through involvement of trained teachers and Anganwadi workers (AWWs). ASHA will be involved in mobilization of these children at community level.

Objective:

- To reduce the prevalence and severity of nutritional anaemia for children of age group 5-10 years.

Strategies:

- IFA supplementation on weekly basis for 52 weeks & Albendazole tablets administration twice a year to the targeted childrens (5-10 years).
- Screening of target groups for moderate/severe anaemia.
- Referral services.

Activities:

1. Procurement of IFA tablets and Albendazole

- a. IFA:** (3602607 * 52 weeks* Rs.30/- per 100 tablets)
No. of units -1873356 X Cost Rs.30 = **Rs. 562.01 lakhs.**

b. Albendazole: (3602607 *2 doses *Rs.119/- per 100 tablets)

No. of units – 72052 X Cost Rs.119 = **Rs. 85.75 lakhs.**

2. Supplementation of IFA tablets and Albendazole

- a. Supplementation of IFA tablets and Albendazole at Schools for School going children of 1st std to 5th Standard for Boys and Girls.
- b. Supervision & Monitoring at Various levels.
- c. Inter-sectoral convergence.
- d. Coverage evaluation study.
- e. IEC/BCC awareness.

Deliverables:

Supplementation of 45 mg of elemental iron & 400 micro grams of folic acid for schools and for out-of-school adolescent girls at AWC.

- Timely distribution of IFA/Albendazole tablets
- Printing and supply of relevant IEC material and activities
- Convergence and quarterly review meetings at State, district and talukas
- Routine monitoring of programme by the MOs, THOs and District & state level program officers.

Proposed budget for NATIONAL IRON PLUS INITIATIVE – Age group (5-10) years (2014-15):

Sl. No.	Particulars	No. of units	Unit cost	Total Cost	FMR code	Remarks
1.	IFA tablets VAT 5.5% Handling Charges 1%	1873356	30	562.01	B.16.2.6.	Total no of IFS tab box required 1873356 @ Rs.30 per box = Rs.56200669 X 5.5 % VAT = Rs.3091037 and 1% Handling charges = Rs.562007 The total budget is Rs.598.54
2.	Albendazole tablets VAT 5.5% Handling Charges 1%	72052	119	85.75	B.16.2.6.	Total no of Albendazole tab box required 72052 @ Rs.119 per box = Rs.8574205 X 5.5 % VAT = Rs.471581 and 1% Handling charges = Rs.85742 The total budget is

						Rs.91.32
3.	Supplementation for Children (5 to 10 Yrs) Annexures to each institute	1.36	5	6.80	B.10.7.4.1	Total no of schools = 72,000 + total no of AWC = 64,000 = 1,36,000 X Rs.5 per set of 5 annexures = Total budget is Rs.6,80,000/-
Total :-				696.66		

Monitoring of Weekly Iron & Folic Acid Supplementation for Adolescents

Weekly Iron & Folic Acid Supplementation (WIFS) programme was launched in the state on 17th July 2013 to reduce prevalence and severity of anaemia in adolescent (10-19 years) population. The beneficiaries are boys and girls of 6th to 10th standard in Govt and Aided schools and Out of School Adolescent girls. The WIFS strategy involves a "fixed day" approach for consumption of Iron and Folic Acid i.e. IFA (Every Monday) and de-worming tablet (one day each in August & February). High compliance in consumption of the IFA tablets is to be ensured by close supervision.

The programme encourages consumption of IFA tablets by Anganawadi worker and class teacher to enhance the value of WIFS in the minds of adolescents as well as the community members.

Cr

eating awareness in adolescents regarding the correct dietary practices to increase iron intake, significance of preventing worm infestation and significance of correct hygiene practices including use of footwear is also part of the programme.

Monitoring:

The programme is monitored simultaneously by Education, Women and Child Development and Health Departments.

Role of Education department:

- **Class level:** Class teacher maintains record of IFA consumption in the attendance register. At the end of the month, the class teacher compiles the information of the number of girls & boys who have taken 4/5 IFA tablets in the month. Similar exercise would also need to be carried out for the de-worming tablets. This information & the information of the stock of tablets is transferred to the monthly reporting format for each class and sent to the nodal teacher as per reporting Format-2.
- **School level:** Nodal teacher submits the consolidated report in Format-3 duly signed by the Head Master/ Head Mistress to Block Education Officer on monthly

basis. Nodal teacher should supervise the implementation of the programme in the school and ensure the following practices:

- Tablet not to be consumed on empty stomach.
 - Consumption of the tablets ½ hour after the mid-day-meal.
 - Tablet should be swallowed in a glass of water and should not be chewed or crushed.
 - IFA supplementation should be withheld in case of acute illness (fever, acute diarrhoea, pneumonia etc.), Severe Acute Malnutrition & in known cases of haemoglobinopathies / history of repeated blood transfusion (which conditions would require specific advice of physician for starting of IFA supplementation).
-
- Information & counselling for improving dietary intake & preventive actions to be taken for worm infestation (correct hygiene practices & use of foot wear) to the students along with nutritional counselling regarding consumption of micro nutrient rich food like, dark green leafy vegetables, lentils & local available Vitamin 'C' rich fruits.
-
- **Block level:** Block Education Officer reviews the monthly report from each school, consolidates all the reports and submits it to the District Education Officer in Format-4.
 - **District level:** The District Education Officer submits the consolidated report to the DHO marking a copy to the State Education Department in Format -5. The DHO forwards the same to the State Health Department.

Role of WCD department: Monitoring is done at various levels which are as follows:

- **At the Anganawadi Centre level (AWC):** Anganawadi worker compiles the monthly data of IFA and de-worming tablet consumption by the adolescent girls of her Anganawadi centre as per Format-7A & forwards it to block ICDS project officer. A copy of the monthly format is given to ANM also.
- **At the Sector level:** The supervisor will compile the information of all anganawadi reports and submits it to the CDPO in Format 7B.
- **At the Block level:** The CDPO will compile block reports & submits it to the District ICDS officer in Format 4.
- **At the District level:** District ICDS officer will submit the consolidated report to DHO / RCHO in Format 5.

Role of Health Department at District:

- Ensure “fixed day” strategy is put in operation in schools and for out-of-school adolescent girls at AWC
- Ensure provision of IEC material and activities to ensure high compliance and demand generation.
- Ensure completion of training/orientation sessions and provision of resource material to block officers, teachers, ICDS supervisor, ANM, AWW, ASHA
- Ensure timely supply of IFA/de-worming tablets to schools and anganawadi centres.
- Review monthly monitoring reports on coverage of school based and out of school programme, compile all the reports of the district & submit to the State Nodal Officer.
- Conduct quarterly meeting to review the programme with Education and ICDS departments.
- Take immediate corrective steps in case of any adverse effect reported - medically by reassuring the child & treating where required, IEC & BCC by explaining the facts with examples / statistics & ensure that a positive report is propagated. In case of misrepresentation / reporting in the media, give immediate corrective reports.
- **PHC Medical Officer:** Is responsible for Overall supervision of the implementation of the programme in the schools and anganawadi centres in his jurisdiction. He should ensure the following points:
 - Tablet not to be consumed on empty stomach.
 - Consumption of the tablets ½ hour after the mid-day-meal.
 - Tablet should be swallowed in a glass of water and should not be chewed or crushed.
 - IFA supplementation should be withheld in case of acute illness (fever, acute diarrhoea, pneumonia etc.), Severe Acute Malnutrition & in known cases of haemoglobinopathies / history of repeated blood transfusion (which conditions would require specific advice of physician for starting of IFA supplementation).
 - Information & counselling for improving dietary intake & preventive actions to be taken for worm infestation (correct hygiene practices & use of foot wear) to the students and adolescent girls at anganawadi centres along with nutritional counselling regarding consumption of micro nutrient rich food like, dark green leafy vegetables, lentils & local available Vitamin ‘C’ rich fruits.

Need for close supervision and monitoring of the programme implementation:

2000 anganawadi centres and 1000 schools will be implementing the programme in each district. The programme needs close supervision and monitoring at district level in view of the vulnerable population (adolescents) involved. The

success of the programme will be reflected in the future through improvement in pregnancy out-come, reduction of mortality & morbidity in women & new-borns and better cognitive development & intelligence.

It is difficult for the RCHO who is the nodal officer for all RCH activities to conduct micro-level monitoring in all schools & Anganawadis. Strict monitoring is required in the following areas:

- Verification of taluka wise indent for IFA and de-worming tablets prepared by Education and WCD departments.
- Verification that tablets are supplied in time to the schools and anganawadi centres.
- Ensure quality training.
- Random check regarding actual consumption of the tablets by the beneficiaries by visiting School/Anganwadi Centres.
- Ensuring proper referral and follow-up of moderately/ severely anaemic cases to higher health facilities.
- Prompt reporting of adverse effects & corrective actions.
- Ensuring timely submission of the reports by both the departments
- Verification & submission to the State.
- Organising quarterly co-ordination committee review meetings.

The RCH Officer has to monitor all components of RCH & it is not possible to undertake focussed quality supervision. Hence one District WIFS Coordinator who is a graduate with MPH/DPH/PGDHHM/MBA HCS qualification is proposed to be hired on contract basis @ Rs.25,000/- per month for 6 months.

Proposed budget:

Sl. No.	Particulars	No. of units	Unit cost	Total Cost	FMR code	Remarks
1.	Hiring HR: District WIFS Coordinator	30	0.25	45.00		Total no of districts 30 X 1 WIFS co-ordinator per district X Rs.25,000/- per month X 6 months = Rs.45.00 lakhs
2.	Mobility support for WIFS coordinator	30	0.02	3.60		WIFS co-ordinator 30 X Rs.2,000/- per month X 6 months = Rs.3.60 lakhs
3.	Purchase of laptop with accessories	30	0.75	22.50		WIFS co-ordinator 30 X 1 lap top per co-ordinator X Rs. 75,000/- per lap top = Rs.22.50 lakhs
Total :-				71.10		

Sl. No.	Activity	No. of units	Unit cost	Total Cost	FMR code
1	HR				

	MOs –	50	0.35	210.00	A.8.1.7.4.1
	1. MBBS	50	0.30	180.00	
	2.AYUSH (BAMS)	704	0.14	1182.72	
	Total :-			1572.72	
	Staff Nurse	76	0.10	91.20	A.8.1.7.4.2
		326	0.08	312.96	
	Total :-			404.16	
	Ophthalmic Assistant	402	0.10	361.80	
	Data Entry Operator	30	0.15	54.00	
2	Hiring of vehicle	402	0.30	1447.20	A.5.1.3
3	Procurement of Laptops with accessories & MS office	402	0.75	301.5	B16.1.6.3.3
4	Miscellaneous & contingency	402	0.10	40.20	A.5.1.6
5	Contingency & stationary expenditure for State programme officer	1	5.00	5.00	A.5.1.7
6	Quarterly convergence Meetings				A.5.1.9
	At State Level	4	0.03	0.12	
	At District Level	120	0.03	3.60	
	At Taluka Level	704	0.03	21.12	
	Total:			24.84	
7	Essential Drug Kit for mobile team	402	0.80	321.16	B.16.2.7.1
8	Printing of RBSK Screening tool cum referral card for children 0 to 6 years	4378075	0.0001	437.80	B.10.7.4.3
9	Printing of RBSK Screening tool cum referral card for children 6 to 16 years	5031042	0.0001	503.10	B.10.7.4.3
10	3 days training to all MOs of delivery points	33	1.65	54.33	
	3 days training to all SNs at delivery points	66	1.65	108.67	
11	Prepare & disseminate guidelines for RBSH	4000	0.001	4.00	A.4.2.1
12	Hand bills for RBSK	20000	0.20	6.00	
13	Mobile Health Team Register for Anganawadi Centres	804	0.005	4.02	
14	Mobile Health Team Register for Schools	804	0.005	4.02	
15	Delivery Point Register	1000	0.005	5.00	
16	Printing of Sun board regarding RBSK	148050	0.003	444.15	
17	Incentive to ASHA	27468 infants with birth defects, 430000 children (0 to 6 yrs) with development delays, 60% of 457468 is 274000	100/case X 274000	274.00	
18	DEIC Manager	6	0.15	8.10	A.8.1.7.4.4

19	Infrastructure	6	25.00	150.00	B5.13.1
20	OAE Equipments	6	3.00	18.00	B16.1.6.3.2
21	Recurring expenditure	6	0.20	1.20	A.5.1.4
22	Referral services	1000	1.30	1300.00	A.5.2
23	IFA tablets VAT 5.5%Handling Charges 1%	2863139	0.0003	858.95	B.16.2.6
24	Albendazole tablets VAT 5.5%Handling Charges 1%	110121	0.00119	131.05	B.16.2.6
25	Convergence meetings at State level	4	0.10	0.40	A.2.12
26	Convergence meetings at District level 2 times in a district	2	0.05	3.0	A.2.12
27	WIFS Campaigns at Block level to promote awareness on Nutritional Anaemia	176	0.10	17.60	A.2.12
28	WIFS Annexures to each institute (43000 schools and 63000 AWCs)	1.36	0.00005	6.80	B.10.7.2
29	IFA tablets VAT 5.5%Handling Charges 1%	1873356	0.0003	562.01	B.16.2.6.
30	Albendazole tablets VAT 5.5%Handling Charges 1%	72052	0.00119	85.75	B.16.2.6.
31	Supplementation for Children (5 to 10 Yrs) Annexures to each institute	136000	0.00005	6.80	B.10.7.4.1
Total:				9527.33	

A.7 Implementation of PC& PNDT programme

The Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 amended in 2002, as **The Pre Conception and Pre Natal Diagnostic Techniques (Prohibition of Sex Selection) – PCPNDT- Act** specifically provides for the 'prohibition of sex selection', for the 'regulation of prenatal diagnostic techniques' and prevention of their misuse for 'sex determination leading to female foeticide'.

The Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 has been enacted by the Government of India to:

- Prohibit sex selection before or after conception.
- Regulate the use of pre-natal diagnostic techniques including ultrasonography for detecting genetic abnormalities or other sex linked disorders in the foetus.
- Allow the use of pre-natal diagnostic techniques including ultrasonography only at registered places and by qualified persons defined under the law.
- Analyze the existing problem of pre-natal sex selection.
- Analyze the declining number of girl children in India (sex ratio)
- Creating awareness about these issues.
- Strengthening PCPNDT Act Implementation.

PCPNDT Act by regulating misuse of PCPNDT techniques for sex selection and promoting of the girl child in the Karnataka state, following steps have been taken by the state to sensitize the community by conducting workshops for general public's, NGOs, Judiciary, service providers and elected members.

To bring in gender equity PC& PNDT Act is being implemented in the state since 2005. A special PNDT cell constituted at state level in 2008 has played a major role in bringing improvement in the female sex ratio..

Major initiatives :.

- Statutory bodies constituted:
 - State Supervisory Board: 20 members
 - State Appropriate Authority: 3 members
 - State Advisory Committee: 8 members
 - District Advisory Committees : 8 members in each.
- For implementing this PC&PNDT Act 1994 and rules 1996, an appropriate authority at district level is Deputy Commissioner of the district.
- Apart from this, the "Assistant Commissioner" of sub divisions of Bijapur, Bagalkote, Davangere, Belgaum, Chitradurga, Mandya, Bidar and Gulbarga districts has been appointed as Appropriate Authority at Sub-district level for their sub divisions where the sex ratio is less in these districts.

- Every Genetic Counseling Centers, Genetic Clinics, Genetic Laboratory, Ultrasound Clinic and Imaging centers are registered under the Act.
- Supervision and surprise visits are done periodically by DAAs.

**Comparisons of Child Sex ratio in Karnataka 1991, 2001 & 2011 Census
(District wise)**

Sl. No	Districts	2001 Census	2011 census
1	RAICHUR	964	950
2	CHAMRAJANAGAR	964	953
3	HAVERI	957	946
4	BAGALKOTE	940	935
5	D.KANNADA	952	947
6	GADAG	952	947
7	KOLAR	965	962
8	MYSORE	962	961
9	YADGIR	952	951
10	UDUPI	958	958
11	BANGALORE (U)	943	944
12	BIDAR	941	942
13	CHICKBALLAPURA	952	953
14	CHITRADURGA	946	947
15	DHARWAD	943	944
16	KODAGU	977	978
17	DAVANAGERE	946	948
18	BIJAPUR	928	931
19	SHIMOGA	956	960
20	KOPPAL	953	958
21	MANDYA	934	939
22	U.KANNADA	946	955
23	CHIKAMAGALUR	959	969
24	TUMKUR	949	959
25	BANGALORE ®	939	950
26	GULBARGA	931	943

27	BELGAUM	921	934
28	BELLARY	947	960
29	HASSAN	958	973
30	RAMANAGAR	945	962
	STATE	946	948

Compared to 2001 census the child sex ratio in 2011 has improved in most districts of Karnataka except 9 districts namely Raichur, Chamarajnagar, Haveri, Bagalkote, Dakshina Kannada, Gadag, Kolar, Mysore and Yadgiri.

Achievements:

Sl.No.	Activity	Progress
1	State cell	In place
2	Workshops	
	State level	Will be in Feb.2014
	District level	21 held
	Taluka level	100
3	Meeting	
	State level	2 (SAB)
	District level	48

I) State PC&PNDT Cell

The special PNDT cell constituted in Karnataka in 2008 is a continued activity. There is an improvement in the female child sex ratio from the census in 2001 to 2011.

Main functions of the cell are

- 1) To regulate use of Pre-natal diagnostic techniques including ultrasound sonography.
- 2) Allow use of Pre-natal Diagnostic techniques only at registered places and by qualified persons defined under the law.
- 3) Create awareness about the issues regarding the existing problems of sex selection and their effects.
- 4) Strengthening PC&PNDT Act implementation.

It consists of:

- One Deputy Director who is in charge of overall implementation of the PC&PNDT programme in the state.
- The Legal Consultant assists the Deputy Director with regard to the legal aspects of the programme like during any violations of the act by suggesting the legal implication of the violations of the PC&PNDT Act.

Achievement: One legal consultant, one data entry operator in position on contract. The cell is active and is implementing the programme in the state. One

more PC & PNDT consultant approved under programme management will assist in monitoring the activities in the state.

Justification

The special PC&PNDT cell is set up to implement the PC&PNDT Act 1994 and Rules 1996 i.e. to regulate the Pre-conception and Pre-natal Diagnostic techniques and prevents their misuse for sex determination leading to female foeticide.

Funding proposed

	No. of Unit	Cost per unit	Total Cost	FMR code
Legal Consultant	1	Rs. 50,000/-	600000	A.7
M&E official	1	Rs. 25,000/-	300000	A.7
Mobility support and office expenses			200000	A.7
TOTAL			1100000	

II) Meeting & Workshops:

This is a continued activity.

- 1) Meetings for capacity building for new district level officer for implementation of the PC&PNDT Act 1996 will be conducted at the District level.
- 2) District Level & Taluk Level sensitization programmes for PCPNDT will be conducted in all the 30 districts and 176 taluks of Karnataka.
- 3) One state level awareness programme will be conducted.
All the sensitization programmes will involve the General Public, NGO's, State Officials, Doctors, Judiciary and Grass root level workers and Media.
- 4) State Advisory committee meetings and Multimember Body meetings will conduct once in 2 months.

Achievement:

- Two state advisory committee meetings were held.
- PC & PNDT workshops were conducted in all the districts and 70 taluks.

Justification

The Workshops will be conducted at the State and Districts level to create awareness and to sensitize the people about the existing problems of the sex selection and reasons for declining sex ratio and long term effects of decline of female child sex ratio in the country. The meeting will also highlight on the various steps to be taken for the implementation of this act.

Funding proposed

	No. of Unit	Cost per unit	Total Cost	FMR code
Capacity building programmes for District level officers at state level	1	2,00,000/-	2,00,000/-	A.7.1
District level sensitization programmes	30	10,000X30	3,00,000/-	A.7.1
Taluk level sensitization programmes	176	5000X176X2	17,60,000/-	A.7.1
State Level sensitization programme	1	5,00,000X1	5,00,000/-	
Meeting expenses	6	5000	30,000/-	A.7.1
TOTAL			27,90,000	

III) State Inspection and Monitoring committee

It is a new activity.

- a) There will be 4 such State Inspection and Monitoring committees one for each division of Karnataka. Each committee will consist of 4-5 members which will include NGOs, Legal Expert, Specialists from Medical fraternity and Social workers.
- b) There will be 9 District Inspection and Monitoring committees for the 9 districts with 4-5 members which will include NGOs, Legal Expert, Specialists from Medical fraternity and Social workers for the 9 declining child sex ratio districts namely
 - 1) Raichur
 - 2) Chamarajnagar
 - 3) Haveri
 - 4) Bagalkote
 - 5) Dakshina Kannada
 - 6) Gadag
 - 7) Kolar
 - 8) Mysore
 - 9) Yadagiri

Funding proposed

	No. of Unit	Cost per unit	Total Cost	FMR code
State Inspection and Monitoring committee visits to the 4 divisions every quarter	4	20,000X4x4	3,20,000/-	A.7.1.1
District Inspection and Monitoring Committee visit to 9 low child sex ratio districts every	9	20,000X9x4	7,20,000/-	A.7.1.1

quarter				
TOTAL			10,40,000/-	

IV. Awards / incentives for informants

Award/incentives for persons informing about the violation of PC&PNDT act. Rs.1000/- to be paid on receiving information of violation and if the violation is proved then the informants will receive Rs. 20,000/-.

Funding proposed

	No. of Unit	Cost per unit	Total Cost	FMR code
Awards/ Incentives for Informants	-	-	5,00,000/-	A.7.1.6
TOTAL			5,00,000/-	

V. Miscellaneous

Funding proposed

	No. of Unit	Cost per unit	Total Cost	FMR code
Miscellaneous	-	-	1,00,000/-	A.7.1.7
TOTAL			1,00,000/-	

	Budget	
Sl. No.	Activities	Amount Rs. In lakhs
1	State PC&PNDT Cell	11.00
2	Meeting & Workshops	27.90
3	State Inspection & Monitoring committee	10.40
4	GPS Mapping facilities / machines	52.80
5	Decentralization of PNDT-NGO-Scheme	270.00
6	IEC	100.00
7	Award/incentives for informants	5.00
8	Miscellaneous	1.00
	TOTAL	478.10

A.8 Human Resources:

Contractual Staff & Services

Contractual staff under NHM has been working at all levels from sub centre to District hospitals. Most of them are technical staff appointed on contract to fill the existing vacancies or as ad ons to cater to the high case loads or to functionalise the facility into 24 x 7 or as a special provision under programme specific interventions like PICU,SNCU,RBSK and RSK etc. The contractual positions are planned for delivery points in SC/PHC/24x7 PHCs/CHC/TH/DH (FRUs).

Salary proposed for specialists and medical officers under RMNCH+A for the year 2014-15 is as per the Cabinet decision of the state government.

Performance appraisal has been initiated and the differential salary based on the performance is planned to be made for the year 2015-16.

Human Resource for SC/PHC/24x7 PHCs/CHC/TH/DH (FRUs)

The following personnel are proposed for 2014-15. There has been an increase in numbers of ANMs, medical officers, Specialists. This increase is as per DHAPs submitted by the districts for the FY 2014-15.

Following table explains the programme under which number of positions proposed along with the budget required.

HR details										Rs. In lakhs		
SL. NO.	CATEGORY	Total no of approved in 2013-14	UNIT COST (In Rs.)		NO OF UNITS		Total no of units proposed in 2014-15	No. of months	AMOUNT		TOTAL COST	FMR code
			HPD	NON HPD	HPD	NON HPD			HPD	NON HPD		
1	ANM	990	7500	7500	375	615	990	12	337.50	553.50	891	A.8.1.1.1.f
		604	7500	7500	200	404	604	6	90.00	181.80	271.8	
	Others (Tribal ANMs)	7	5000	4000		7	7	12	0.00	3.36	3.36	A.8.1.1.1.h
2	STAFF NURSE											
a	DH	35	14000	12000	20	51	71	12	33.60	73.44	107.04	A.8.1.1.2.a
			14000	12000	4	53	57	6	3.36	38.16	41.52	
b	FRUs	279	14000	12000	100	220	320	12	168.00	316.80	484.8	A.8.1.1.2.b
			14000	12000	56	198	254	6	47.04	142.56	189.6	
c	Non FRU SDH/ CHC	165	14000	12000	98	165	263	12	164.64	237.60	402.24	A.8.1.1.2.c
			14000	12000	36	117	153	6	30.24	84.24	114.48	
d	24 X 7 PHC	2950	14000	12000	943	1909	2852	12	1584.24	2748.96	4333.2	A.8.1.1.2.d
e	Non- 24 X 7 PHCs	35	14000	12000	96	15	111	12	161.28	21.60	182.88	A.8.1.1.2.e
			14000	12000	37	12	49	6	31.08	8.64	39.72	
3	CH STAFF NURSE											
a	SNCU	438	14000	12000	102	336	438	12	171.36	483.84	655.2	A.8.1.1.2.f
			14000	12000	32	161	193	6	26.88	115.92	142.8	
b	NBSU	376	14000	12000	100	276	376	12	168.00	397.44	565.44	
c	PICU	45	14000	12000	12	33	45	12	20.16	47.52	67.68	
d	NRC	80	14000	12000	24	56	80	12	40.32	80.64	120.96	
4	LTs											
a	CHC/FRU	149	14000	12000	45	104	149	12	75.60	149.76	225.36	A.8.1.2.1.c
5	Specialists											
5	OBG	100	100000	100000	55	56	111	12	660.00	672.00	1332	A.8.1.3.1.b
6	PEDIATRICIAN		100000	100000	48	45	93	12	576.00	540.00	1116	A.8.1.3.2.b
7	ANESTHETIST		100000	100000	43	34	77	12	516.00	408.00	924	A.8.1.3.3.b
8	CH PEDIATRICIAN (PICU)	15	100000	100000	4	11	15	12	48.00	132.00	180	A.8.1.3.5.a
9	CH PEDIATRICIAN (NBSU)	0	100000	100000	34	0	34	6	204.00	0.00	204	A.8.1.3.5.b
	Medical Officers											
10	Medical officer (24*7 PHC, CHC/FRUs)	80	60000	60000	40	40	80	12	288.00	288.00	576	A.8.1.5.5
			60000	60000	90	65	155	6	324.00	234.00	558	
11	Medical officer (SNCU, PICU & NRC)	86	60000	60000	21	68	89	12	151.20	489.60	640.8	A.8.1.5.6
12	MOs FOR RBSK											

	teams											
a	MBBS	184	60000	60000	30	154	184	12	216.00	1108.80	1324.8	A.8.1.7.4.1
b	AYUSH	620	28000	28000	156	464	620	12	524.16	1559.04	2083.2	
13	SNs FOR RBSK teams	402	14000	12000	92	310	402	12	154.56	446.40	600.96	A.8.1.7.4.2
14	Ophthalmic assistant FOR RBSK teams	402	10000	10000	92	310	402	12	110.40	372.00	482.4	A.8.1.7.4.3
15	DEIC managers	6	15000	15000	3	3	6	9	4.05	4.05	8.1	A.8.1.7.4.4.m
	Others											
16	RMNCH/FP Counselors	40	10000	10000	10	30	40	12	12.00	36.00	48	A.8.1.7.5.1
a	RMNCH/FP Counselors (New post proposed)		10000	10000	10	30	40	6	6.00	18.00	24	
17	Adolescent Health counselors	0	10000	10000	228	0	228	6	136.80	0.00	136.8	A.8.1.7.5.2
18	Honorarium to ICTC counselors for AH activities	172	16000	16000	172	0	172	12	330.24	0.00	330.24	A.8.1.7.5.3
19	Others (Refrigerator mechanic)	18	15000	15000	18	0	18	12	32.40	0.00	32.4	A.8.1.7.7
	Others (Refrigerator mechanic) NEW POST		15000	15000	10	0	10	6	9.00	0.00	9.00	
20	Staff for Training Institutes/ SIHFW/ Nursing Training (SNs)	8	14000	12000	0	8	8	12	0.00	11.52	11.52	A.8.1.7.8
	Staff for Training Institutes/ SIHFW/ Nursing Training (LTs)	3	14000	12000	0	3	3	12	0.00	4.32	4.32	
21	Support staff for SNCU/ NBSU/ NBCC/ NRC etc											
a	CH counselor (SNCU)	22	10000	10000	5	17	22	12	6.00	20.40	26.40	A.8.1.7.5.4
			10000	10000	2	13	15	6	1.20	7.80	9.00	
b	DEO (SNCU)	0	12000	12000	8	29	37	6	5.76	20.88	26.64	A.8.1.11.f
c	Attender (SNCU)	0	8000	8000	32	116	148	6	15.36	55.68	71.04	
d	Diet Counsellor (NRC)	20	10000	10000	8	12	20	12	9.60	14.40	24.00	
e	Attender (NRC)	20	3500	3500	8	12	20	12	3.36	5.04	8.40	
f	Cook (NRC and MNRC)	20	5000	5000	15	31	46	12	9.00	18.60	27.60	

Human Resource under child health

1. Pediatrician:-

For Pediatric Intensive Care Unit: continued activity.

- In order to ensure intensified services, the post of one additional Pediatrician per PICU had been sanctioned in 2012-13, as there is only one Pediatrician who manages the regular Pediatric OPD, In-Patient, SNCU&NRC. This had been approved in 2013-14. It is proposed to be continued during 2014-15 also.

2. Pediatrician for NBSU in HPD

New activity

- 84 of the 166 NBSUs do not have Pediatricians (50%)
- 46 out of the 166 NBSUs are situated in HPDs. Out of these 46 NBSUs, 34 do not have Pediatricians (75%). It is proposed to appoint Pediatricians to these NBSUs.

To make the FRUs functional in the high focused districts the following proposal is made.

1. To retain the Pediatrician who is working in the FRU of high focused districts, difference between the salary that they are drawing and the amount approved for contract pediatricians and this difference amount may be met out of NHM funds.
2. To motivate pediatricians from non-high focused districts to work in high focused districts, they may be paid the difference between the salary that they are drawing and the amount approved for contract pediatricians and this difference amount may be met out of NHM funds.

3. Medical Officers for SNCUs-

Continued activity

- 69 MOs for SNCUs : 66 MOs for 22 Non Medical college SNCUs @ 3 MOs per SNCU for 22 existing non-Medic SNCUs has been approved since 2011-12. additional 3 MOs are proposed for the new SNCU proposed in Taluk hospital Sirsi. hence a total of 69 Medical Officers have been proposed for the SNCUs.
- Medical Officers have not been provided for Medical College SNCUs in the previous years. Hence no Medical Officers have not been proposed for the 3 other new SNCUs of Bowring Hospital Bangalore, Wenlock hospital Mangalore, & District Hospital Bellary.

4. Staff Nurses for SNCU, NBSU and PICU:-

Continued Activity

- **SNCU** : 631 Staff Nurses for SNCUs at
 - 16 staff nurses per SNCU (12 for SNCU, 3 Fetal care Staff Nurses for Labour wards & 1 for SNCU follow up) are proposed for the 23 Non Medical College SNCUs (22 old & 1 new at Taluk hospital Sirsi)
 - 19 staff nurses per SNCU (12 for SNCU, 3 Fetal care Staff Nurses for Labour wards, 3 for Ventilatory care & 1 for SNCU follow up) are proposed for the 14 Non Medical College SNCUs (11 old & 3 new at 4 SNCUs of Bowring Hospital, Bangalore, Wenlock hospital Mangalore, District Hospital Bellary)
- **NBSU** :376 Staff Nurses have been proposed for NBSUs in 2013-14, at 2 staff nurse per NBSU for 144 facilities and 4 staff nurse per NBSU for 22 institutions with high delivery load /low permanent staff nurses.
- **PICU** :45 Staff Nurses for PICUs at 3 staff nurses per PICU

Totally 1052 staff nurses have been proposed under child health

Child Health Counselors:-

- 22 CH counselors had been sanctioned in 2013-14 for non medical college SNCU.
- It is proposed to appoint 1 Counselor to each SNCU attached to Medical College also in view of the fact that these SNCUs have the most admissions. The relatives of these new borns are very vulnerable & would need Counseling regarding the illness, care at discharge & also the importance of Follow up.
- Totally 37 counselors are proposed for the 33 existing and 4 additional SNCUs.

Hiring of Support Staff (Attenders) for SNCUs:

It is a new activity.

Maintenance of high level of Hygiene is a pre-requisite for optimum Infection Control. There is an acute shortage of Attenders in all District Hospitals. The Contract Attenders hired under State Budget in the District Hospitals not under Medical Colleges are not sufficient for maintaining the cleanliness of the hospital. Moreover, they are posted to various departments on rotation. Hence they do not acquire the necessary skills for maintenance of the equipments & the babies.

There is provision for hiring 4 Support Staff per SNCU as per the MNH tool kit. It is proposed to hire 144 attenders at 4 per SNCU for all the 33 functioning SNCUs & 4 proposed SNCUs.

Human Resources under Child Health 2014-15									
Name of the District	Pediatrician		Medical Officers	Staff Nurses			CH Counselor	Group D NEW	Data Entry Operator NEW
	PIC U	NBS U NEW	SNC U	SNC U	NBS U	PIC U	SNC U	SNC U	SNC U
Bangalore Rural	0	0	0	0	8	0	0	0	0
Bangalore Urban	0	0	6	89	6	0	5	20	5
Ramanagara	0	0	3	16	6	0	1	4	1
Chitradurga	1	0	3	16	12	3	1	4	1
Tumkur	1	0	3	16	16	3	1	4	1
Kolar	1	0	3	16	10	3	1	4	1
Chikballapur	0	0	3	16	12	0	1	4	1
Shimoga	0	0	0	19	14	0	1	4	1
Davanagere	1	0	6	32	14	3	2	8	2
Chamarajnagara	1	0	3	16	10	3	1	4	1
Hassan	0	0	0	19	16	0	1	4	1
Udupi	1	0	3	16	4	3	1	4	1
Chikmagalore	1	0	3	16	16	3	1	4	1
Dakshina Kannada	1	0	3	35	8	3	2	8	2
Mandya	0	0	0	19	14	0	1	4	1
Mysore	0	0	0	19	24	0	1	4	1
Kodagu	1	0	3	16	8	3	1	4	1
Belgaum	0	0	0	19	30	0	1	4	1
Bijapur	1	4	3	16	10	3	1	4	1
Dharwad	1	0	3	35	4	3	2	8	2
Uttara Kannada	0	0	6	32	22	0	2	8	2
Gadag	1	5	3	16	12	3	1	4	1
Haveri	1	0	3	16	12	3	1	4	1
Bagalkot	1	4	3	16	20	3	1	4	1
Gulbarga	1	4	3	16	12	3	1	4	1
Yadgir	0	3	0	0	8	0	0	0	0
Koppal	0	6	3	16	16	0	1	4	1
Raichur	0	3	0	19	10	0	1	4	1
Bellary	0	5	0	35	12	0	2	8	2
Bidar	0	0	0	19	10	0	1	4	1
HPD	4	34	15	134	100	12	8	32	8
Non HPD	11	0	54	497	276	33	29	116	29
Total	15	34	69	631	376	45	37	148	37

HUMAN RESOURCE FOR NRCs							
Sl. No.	Districts	Medical Officer	Staff Nurse	Nutrition Counsellor	Social Worker	Attender	Cook
1	Bagalkote	1	10	3	3	6	3
2	Bangalore (R)	0	0	0	0	0	0
3	Bangalore (U)	3	15	3	3	6	3
4	Belgaum	1	11	3	3	6	3
5	Bellary	1	11	2	2	4	2
6	Bidar	1	8	2	2	4	2
7	Bijapur	1	4	1	1	2	1
8	Chamarajanagar	1	7	2	2	4	2
9	Chikkaballapur	1	7	2	2	4	2
10	Chikkamagalur	1	7	2	2	4	2
11	Chitradurga	1	7	2	2	4	2
12	Dakshina Kannada	1	4	1	1	2	1
13	Davangere	1	10	3	3	6	3
14	Dharwad	1	15	3	3	6	3
15	Gadag	1	7	2	2	4	2
16	Gulbarga	1	4	1	1	2	1
17	Hassan	1	11	2	2	4	2
18	Haveri	1	7	2	2	4	2
19	Kodagu	1	7	2	2	4	2
20	Kolar	1	7	2	2	4	2
21	Koppal	1	10	3	3	6	3
22	Mandya	1	8	1	1	2	1
23	Mysore	1	8	2	2	4	2
24	Raichur	1	11	2	2	4	2
25	Ramanagaram	1	7	2	2	4	2
26	Shimoga	1	12	2	2	4	2
27	Tumkur	1	7	2	2	4	2
28	Udupi	1	7	2	2	4	2
29	Uttara Kannada	1	4	2	2	4	2
30	Yadgiri	1	4	1	1	2	1
	Total of HPD	8	61	15	15	30	15
	Total of non HPD	23	176	44	44	88	44
	TOTAL	31	237	59	59	118	59

HONARARIUM,TA-DA & CONTINGENCIES TO 86 ICTCs

Activity Proposed: Honorarium/TA-DA/ to Counselors and Lab technicians, Contingencies to 86 ICTCS of PHCs and CHCs integrated under NRHM

Continued since FY 2010

Achievements: 172 staff of 86 ICTCs integrated with NRHM are availing honorarium ,TA/DA and contingencies from NRHM funds.

Justification: Since January 2010, based on the directive from DG, NACO and Chief Financial Officer, NACO – AAP FY 2009-10, that the salaries of Counsellors and Lab Technicians working in 83 ICTCs located in PHCs would be borne from NRHM funds, and the same was done by NRHM since then as a part of integration. But the number of ICTCs were increased to 86 PHCs in the recent past, which are essential for maintaining the tempo of counseling and testing in the rural areas since 2013-14. Hence it is proposed to provide salaries to 172 staff (LTs and Counselors) of 86 ICTCs integrated with NRHM.

Deliverables: 172 staff of 86 ICTCs integrated with NRHM shall avail honorarium ,TA/DA and contingencies for the FY 2014-15.

Funding Proposed: INR 33024000

SI no	Particulars	No of Units*	Cost per unit in Rs	Total Cost in Rs	FMR code
1	Honorarium ,TA/DA for LTs	86	15500	15996000	A.8.1.7.5.3
2	Honorarium ,TA/DA for Counselors	86	15500	15996000	
3	Contingencies to ICTCs (86 facilities)	86	1000 per month	10032000	
	Total			Rs 33024000	

A.9 Training

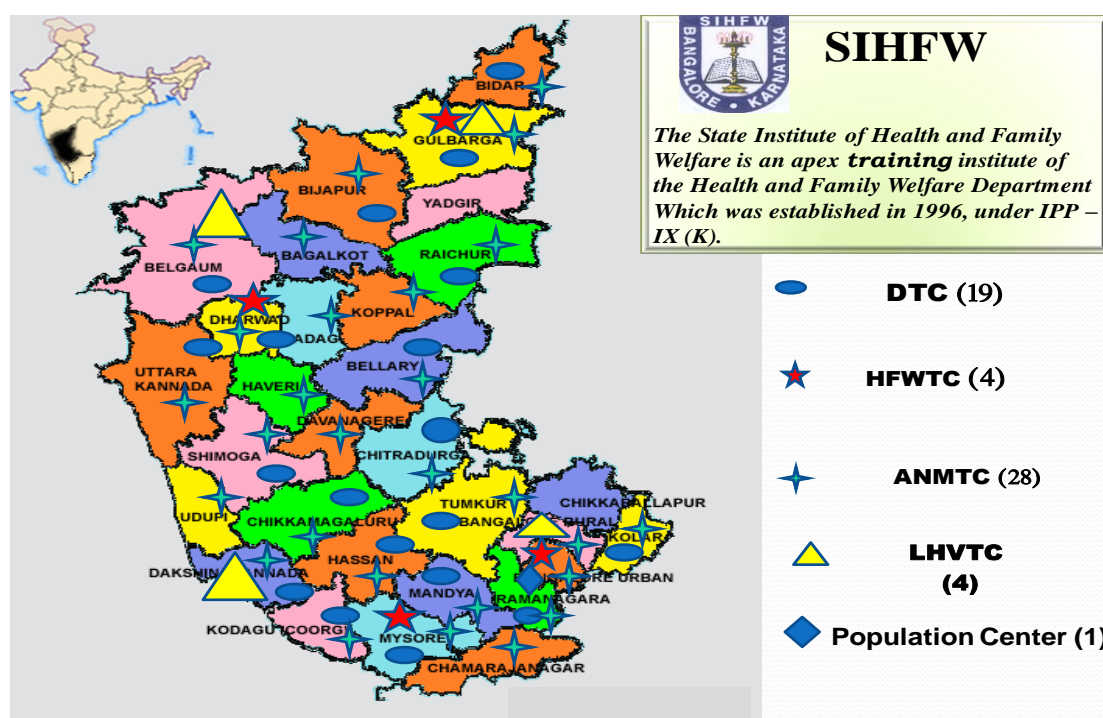
Introduction

The State Institute of Health and Family Welfare is an apex training institute of the Health and Family Welfare Department which was established in 1996, under IPP –IX (K). It is recognized as one of the Collaborative Training Institutes for NIHF, New Delhi and a nodal agency for e-learning and Distance education courses.

SIHFW caters to the capacity building of all cadres of the department in technical and administrative skills. Main training programmes under NHM includes RMNCH + A, and all National programmes. Community health workers training viz. training programme of ASHAs are also taken up by the institute. The training programmes include both theory as well as hands on training. This enables to enhance the skills among the health staff to provide effective quality services at facilities identified as delivery points.

The Institute is running a Certificate of Public Health Nursing Course (CPHN), an eighteen months course in public health nursing for in service Senior Health Assistants (F) in a batch size of 30. One batch of training has been completed and second batch training is on.

SIHFW is headed by Director and is assisted by Joint Director, 10 deputy directors and an administrative wing. It has a network of 4 HFWTCs, 19 DTCs, 28 ANMTCs and 4 LHVTCs in the various districts to meet the training needs. State Population Center also works in coordination with Director SIHFW.



Objectives:

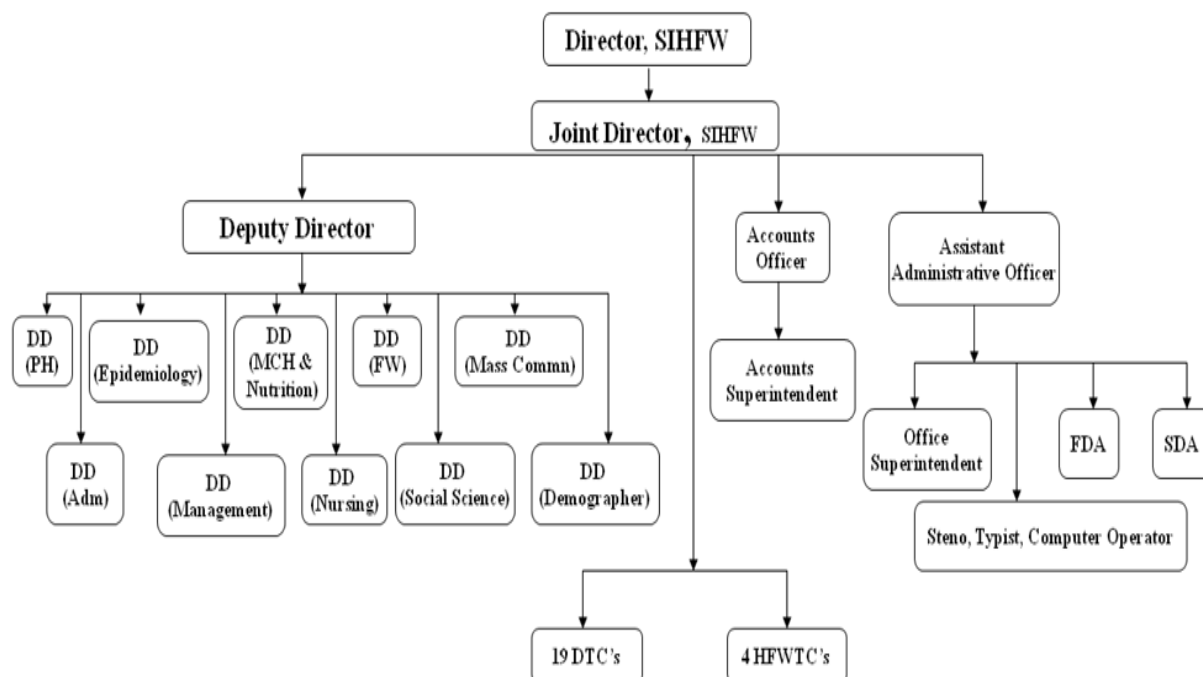
- To plan, implement and monitor all trainings both at state and district levels.
- To develop training manuals and up-dating of existing curriculum for basic trainings and in service trainings.
- To organize Training of Trainers programmes.
 - To establish a quality assurance cell for monitoring & evaluation of all trainings.
 - To continue distance learning and e-learning courses in collaboration with NIHFV.
 - Validating and updating the training data of all districts in TMIS software.

Strategies:

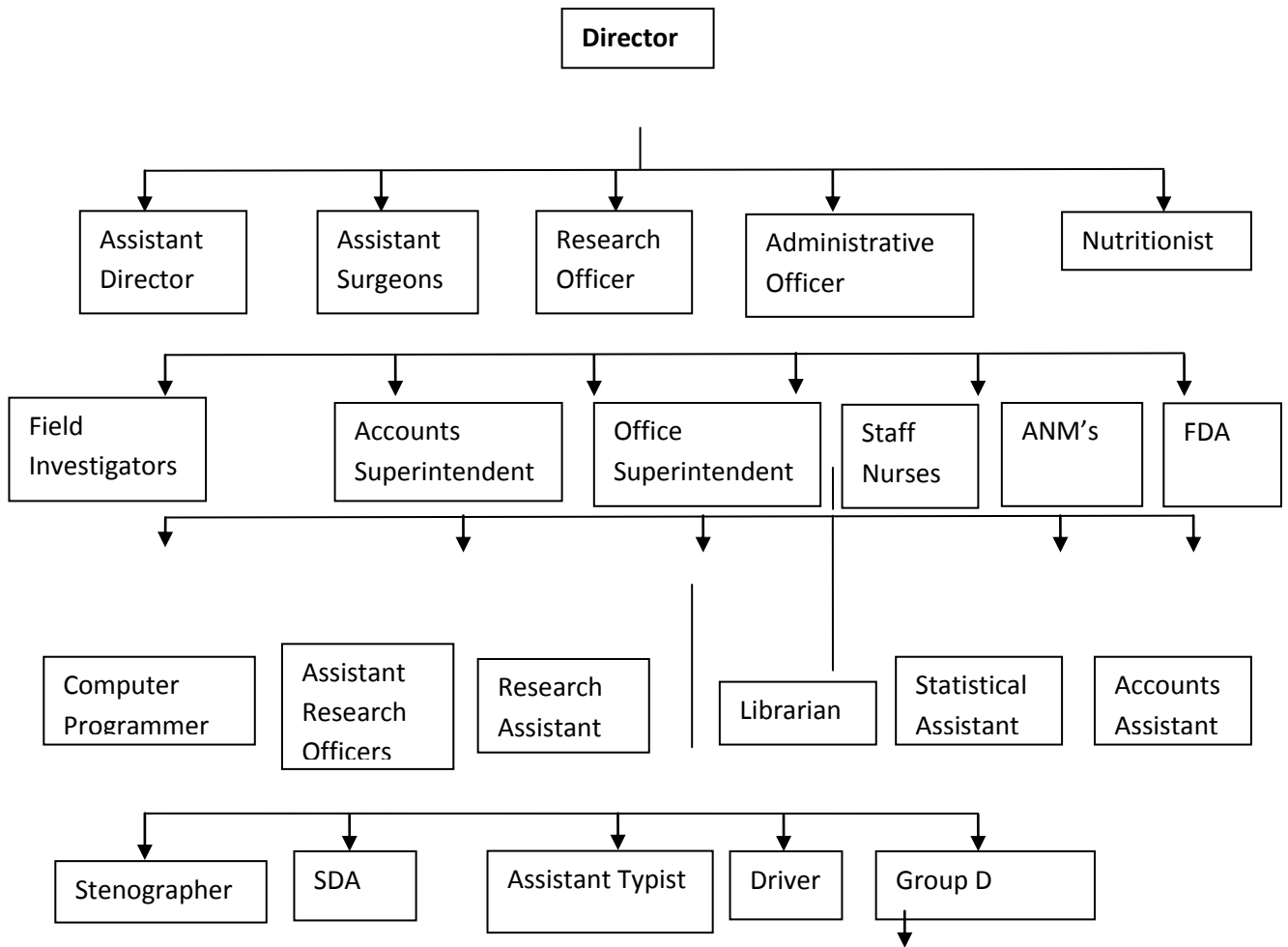
- Strengthening of all the training facilities both at state and district level including infrastructure and HR
 - Preparation and implementation of training calendar (CTP) for all the health personnel as per GOI guidelines.
 - Continuous monitoring & supportive supervision of all the trained personnel.
 - Ensuring quality assurance services
- Initiation of research activities and new public health programs (i.e BSc Community Health, PGDHEP, distance learning courses etc.)

Organogram of SIHFW

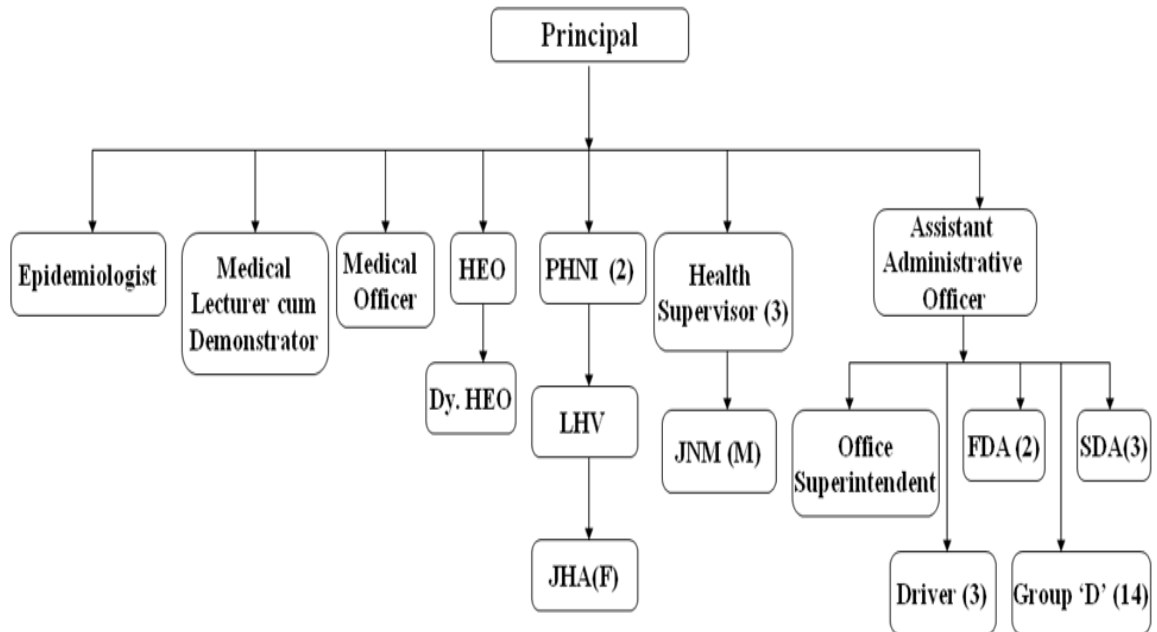
State Institute of Health & Family Welfare



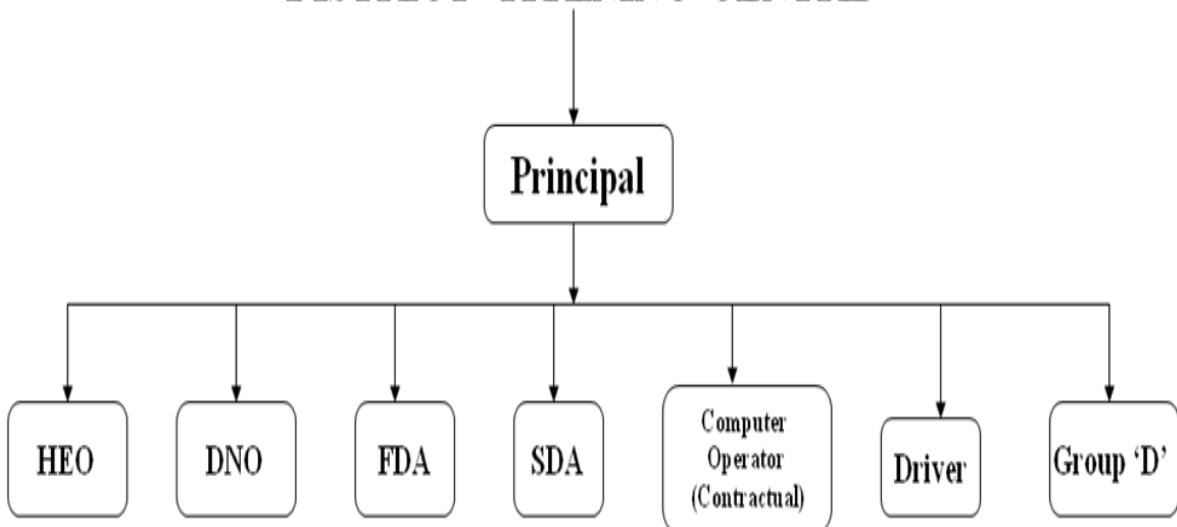
Population Centre



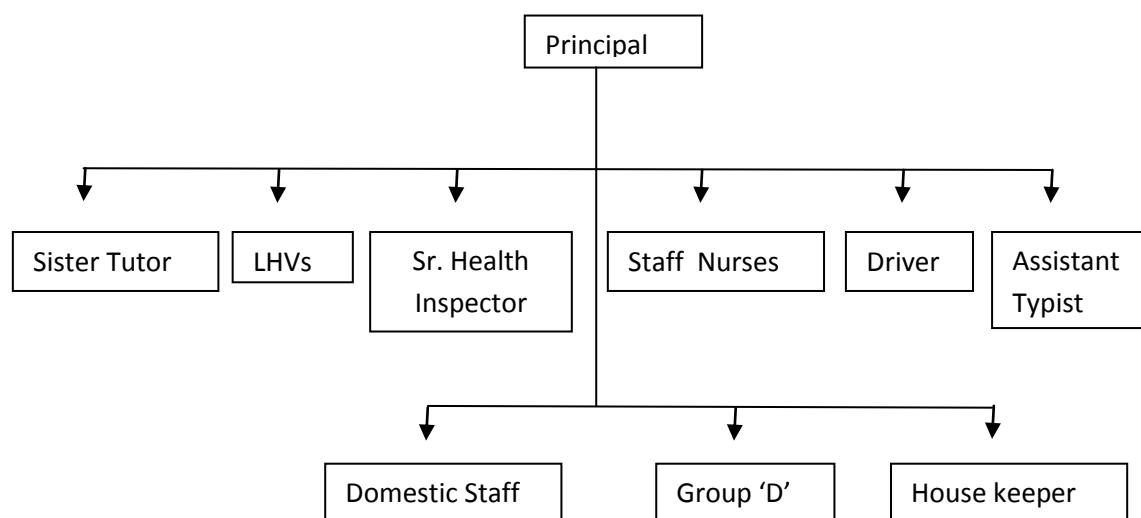
HEALTH & FAMILY WELFARE TRAINING CENTRE



DISTRICT TRAINING CENTRE



ANM Training Centre



Trainings for the year 2014 -15

FMR A.9 - TRAINING

A.9.1 Skill lab

A.9.1.1 Setting up of skill lab:

It is a continued activity GoI Initiative:

In the Financial year 2013-14 ROP approval was given in the second supplementary PIP for establishment of 5 skill labs at ANMTC's/ District Hospitals of KC General Hospital Bangalore, Bidar, Bagalkot, Chamarajnagar and Gadag. Process for infrastructure establishment and procurement of equipments is initiated.

For the Financial year 2014-15, it is proposed to establish 10 skill labs at ANMTC's/DH of 10 districts namely Belgaum, Dharwad, Gulbarga, Bellary, Dakshina Kannada, Davanagere, Shimoga, Mysore, Kolar and Tumkur.

Achievement

Procurement of equipments to five skill labs is under process.

Justification:

As per the guidelines of Government of India, to improve the skills and knowledge of health service providers at delivery points the skill labs have been started. Another 10 skill labs have been proposed in a phased manner for the FY 2014-15 in 10 districts. Hence this activity is proposed.

Deliverables: Skills and knowledge assessment of frontline health worker

It is planned to establish 10 skill labs in identified 10 districts.

Funding proposed

SI No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Setting up of skill lab	10	20,00,000	200.00 Lakhs	A.9.1.1	Strengthening of infrastructure- civil works, addition and alterations, water supply, electrical repair, generator supply etc.
2		10	25,00,000	250.00 Lakhs		Equipments & mannequins
3		10	50000	5.00		Consumables

				Lakhs		(recurring)
4		10	3,00,000	30.00 Lakhs		Teaching and learning materials (2 computers, 2 laptops, 1 LCD projector, photocopier etc.)
5		10	1,29,600	12.96 Lakhs		POL for generator - Diesel @ 10 lts/day (Rs.60*10= Rs. 600) includes oil *24days*9 months (recurring)
	Total			497.96 Lakhs		

A.9.1.2: Human Resources for Skill Lab

Funding Proposed

SI No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Human Resources	15	396000	59.40 Lakhs	A.9.1.2	Salary for 1 doctor @ Rs. 66000(includes salary Rs. 60000 + Rs. 5000 accommodation + Rs.1000 mobile reimbursement * 6 months)
2		15	396000	59.40 Lakhs		Salary for 5 nurse trainers @Rs. 66000 (includes salary Rs.60000+Rs 5000 accommodation+ Rs.1000 mobile reimbursement per month) *6 months Rs 12000/- salary for SNs per month as per GOK consensus
3		15	72000	10.80 Lakhs		Data entry Operator Rs 12000X 6 months
4		15	72000	10.80 Lakhs		Multipurpose Health Worker Rs 12000x 6 months
	Total			140.40 Lakhs		

A.9.1.3: Training motivation and follow up visit

Budget proposed for training 2 districts one batch of 16 participants

Item	Cost
TA (to and fro travel but disbursement as actual and as per entitlement) Rs. 3000*16	48000
DA + Accommodation disbursement ANM/Nurses @400*10*6days	24000
Doctor/ANM/Nurse doctors @ 700*6*6 days	25200
Teaching material, course material and miscellaneous expenses Rs 250*16	4000
Lunch and tea for the trainee (Rs 200 * 16 * 6 days)	19200
Sub Total	120400
IOH (@15%)	18060
TOTAL 138460 * 8 batches	1107680

Funding Proposed

SI No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Training motivation and follow up visit	8	138460	11.08 Lakhs	A.9.1.3	

A.9.1.4: Onsite mentoring at delivery points

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Onsite mentoring at delivery points	9	375000	33.75 Lakhs	A.9.1.4	

Item	Cost
Hiring of vehicle (2000/day *15 days) for 15 days field visit including to and fro journey	30000/month
DA + Accomodation (Doctors/skill lab trainers both doctor/nurse other supervisor @1500) 1500 * 2 skill lab trainers *15 days	45000/month
Total per mentoring visit of 15 days	75000
Total mentoring visit per year (75000*9months * 5 districts)	3375000

A.9.2.2 Other activities

A.9.2.2.1 - Annual Maintenance grant for Minor repairs and maintenance for SIHFW and DTCs/HFWTCs:

It is a new activity:

At present there is no separate AMG provided for these training institutes – SIHFW, DTC / HFWTC and funds required for this activity can't be met out of the IOH component of the trainings.

ANMTCs/LHVTCS separate AMG has to be provided to these institutes as there is no user fee or other trainings to be met out of IOH funds.

Justification:

SIHFW is an Apex training institute and day to day expenses are met by IOH cost. This is not sufficient for maintaining the training institute. Hence it is proposed to make provisions for annual maintenance funds.

As the trainings are residential it is mandatory to have smoke alarms and fire extinguisher.

Funding proposed

SI No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Annual Maintenance grant for Minor repairs and maintenance for SIHFW and DTCs/HFWTCs	1	500000	5.00 Lakhs	A.9.2.2.1	
2	Annual Maintenance grant for Minor repairs and maintenance for DTCs/HFWTCs	19+4	1.00	23.00 Lakhs		
3	LHVTCS	4	2.00	8.00 Lakhs		
	TOTAL			36.00 Lakhs		

A.9.2.2.2 Developing systems for monitoring and evaluation of training programs and other activities (Hiring teaching and support staff to DTCs, HFWTCs and SIHFW) and support to ANMTCs.

It is a continued activity:

Most of the training institutes are short of training faculty and vehicles for mobility support for which hiring of technical staff and vehicle for monitoring and evaluation is very essential.

It is proposed to hire HR to manage, monitor and evaluate concurrent trainings (15 clinical and 3 Non-clinical) and post training skill and service activities at

delivery points and to take corrective measures and feedback, in the form of mobility support is needed at State/Regional/District training centers .

Justification:

Evaluation of the trainings are done in three phases mainly pre training, during training and on the job evaluation. For on the job monitoring and evaluation and mobility of DDs and DTC/HFWTC principals hiring of vehicle is proposed. Due to increased costs, the vehicle procurement through hiring agency is projected at @ Rs. 30000/- per month. 10 Deputy Directors at State level will be training nodal officers for monitoring and evaluation of 30 districts. It is proposed to hire 7 vehicles (3 are maintained by State) for SIHFW. At district level 21 (2 are maintained by state) is proposed.

Hiring of teaching and support staff to SIHFW/HFWTCs/ DTCs:

There are sanctioned posts of 23 Health Education Officers (HEOs) and 23 posts of District Nursing Officers (DNOs) as teaching and training faculty. These faculty help in organizing and conducting trainings and conduct trainings themselves for paramedical staff. They have undergone TOTs like ARSH, HBNC, IMEP, SBA, IMNCI and IUCD etc. At present 21 posts of HEOs and 20 posts of DNOs are vacant. Now it is proposed to fill up these posts on contractual basis. It is also proposed to hire 27 Data Entry Operators (DEOs) one for each of the 19 DTCs, 4 HFWTCs and 4 for SIHFW through outsourcing agency. The DEOs will collect, collate, feed and report all the training data.

Totally 110 CUG Sims are in use under 3 different plans and Rs. 40000/m is proposed for monthly bill.

ANMTCs:

There are 28 Govt. ANM training centers (19 ANMTCs funded by state Govt. and 9 are funded by NHM) and around 30 Pvt. ANMTCs. At present 704 trainees will be completing their course in Sep 2014.

Budget for ANMTCs:

- Human Resource: Hiring of teaching and support staff.
- Maintenance cost (O E etc.)
- Support for field visits.
- Conducting examination.
- Stipend to trainees

Funding Proposed

SI No .	Activity	No of Units	Cost Per Unit	Total	FM R Co de	Remarks
1	Developing systems for monitoring and	7	360000	25.20 Lakhs	5.2.1	Hiring of vehicle @ Rs. 30000 Per month for 10

	evaluation of training programs and other activities				Deputy Directors (3 are maintained by the state)
2		21	360000	75.60 Lakhs	Hiring of vehicle @ Rs. 30000 Per month per DTC/HFWTC (Two government vehicles are in use)
3	CUG Sim	12 m	40000	4.80 Lakhs	Totally 110 CUG Sims are in use under 3 different plans.
4	Staff for training institute/SIHFw/Nursing training(Hiring teaching and support staff to DTCs, HFWTCs and SIHFw)	27	180000	48.60 Lakhs	Hiring of Data entry operators at SIHFw 4 nos and one each at 19 DTC and 4 HFWTC @ Rs. 15000 per month * 12 months Annexure-I
		41	240000	98.40 Lakhs	Hiring 21 HEO & 20 DNO for DTC/HFWTC@ Rs. 20000 per month * 12 months Annexure-I
		1	675000	6.75 Lakhs	Hiring of IT Manager@ Rs. 75000 per month*9 months
		2	540000	10.80 Lakhs	Hiring of Technical assistant (IT) @ Rs. 60000 per month* 9 months
5	Provision for Tablets for DDs	10	75000	7.50 Lakhs	
6	Laptops for Consultants	4	75000	3.00 Lakhs	
7	Support to ANMTCs	1	378401 00	341.61 Lakhs	Annexure-II
	TOTAL			622.26 Lakhs	

A.9.2.2.3 Establishment of Internal Quality Assurance Cell, database management software at district & State and e- learning at SIHFw

It is a new activity: NIHFw Initiative

Internal Quality Assurance Cell: Is to maintain and improve the quality of training programs and other elements affecting them. It involves specifying the quality and intended outcomes of training programs, designing, implementing and reviewing the instruments of quality such as templates and procedures.

Data base management software for TMIS: Involves tracking and record keeping of trainers, trainees and the types of trainings held with details each year at State and DTC/HFWTC levels in smart card mode.

Operationalization of e- learning courses: SIHFw is recognized as one of the centers for e-learning and distance learning education programs by NIHFw.

The e-learning courses are e-PDC, e-PMSU and Distance courses are applied Epidemiology, Nutrition and Health Education

It is proposed to train 20 program officers for e-learning of PDC and 80 in 2 batches of block program managers for PMSU courses.

Operationalization of e- learning courses, Data base management software for TMIS and internal Quality Assurance Cell at SIHFW: As per the e-mail of Governance expert I & TSP, NIHFW on 4/11/2013 budget proposal for 2014 -15 for the below 3 components is included

Funding proposed

SI No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Establishment of Internal Quality Assurance Cell,	1	916000	9.16 Lakhs	A.9.2.2.3	Establishment of Internal Quality Assurance Cell at SIHFW
2	database management software at district & State	1	805000	8.05 Lakhs		Infrastructure and budget requirement at state for implementation of Training data base software.
3	and e- learning at SIHFW	1	7843000	78.43 Lakhs		Infrastructure and budget requirement at 23 DTC/HFWTC for implementation of Training data base software.
4		1	3012500	30.12 Lakhs		Infrastructure and budget requirement for operationalising e-learning courses in the SIHFW
	Total			125.76 Lakhs		Annexure III.IV,V,VI

A.9.2.2.4 Provision of Smart cards

It is a new activity:

It is proposed to provide smart cards to all the health staff except Group D officials working in the department of health and family welfare. The card will capture all the training data of the concerned official who has undergone training at various training centers. There is a provision to add training information as and when they undergo training. This will help to assess the status of training load so that proper training calendar can be prepared and implemented. This will also avoid duplication of training by the same official.

One I T person and support staff will feed current training information at all the districts in their respective training centers, later handover to HR persons proposed at A.9.2.2.2

Funding proposed

SI No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Provision of Smart cards	30000	250	75.00 Lakh	A.9.2.2.4	
	Smart card reader	5	12500	0.62 Lakh		
	Design, Development and interfacing Web portal to ERP Training management Software	5	78500	3.92 Lakh		
	Maintainance	1	98000	0.98 Lakh		
	Total			80.52 Lakh		

A.9.3 Maternal Health

Objectives:

- Up grading the skills and knowledge of health care providers in providing Antenatal, Natal, Postnatal, RTI/STI and safe abortion services aiming in reduction of MMR and IMR.
- To strengthen the health care providers at delivery points to diagnose and manage obstetric complications.
- To improve the quality and utilization of the skills learnt under maternal health trainings.
- To provide community based maternal health care.

A.9.3.1.3 - Training of Staff Nurses in SBA

It is a continued activity:

Staff Nurses both regular and contractual at 24X7 PHC, CHC's including FRU's & district hospitals will be trained at identified centers at district and sub district hospitals including Medical Colleges.

During the training, participants will be trained to:

- Provide quality care and counseling to the woman during antenatal, natal and postpartum period.
- Identify danger signs during pregnancy, labour and postpartum period along with the danger signs in newborn; provide supportive care prior to referral.
- Monitor labour using partograph.
- Practice active management of third stage of labour.
- Follow routine infection prevention practices during pregnancy and child birth.

Training sites – DTCs/HFWTCs and identified district and sub district hospitals including Medical Colleges.

Trainers - SBA TOTs

Trainees - Staff Nurses

Batch size - 3-4 per Batch depends on delivery load.

Duration - 21 days (6 Days class room teaching and 15 days hospital posting.)

Achievement: Up to Feb 2014 totally 6414 Staff Nurses are trained in SBA training.

Financial Year	2011-12		2012-13		2013-14 (Apr 2013-Feb2014)	
Target/Achievement	Targ et	Achievem ent	Targ et	Achievem ent	Targ et	Achievem ent
	500	1339	1500	1073	600	389

Justification:

The training will enhance knowledge, confidence and provide skills for early identification of complications during pregnancy, childbirth and post-partum period.

Deliverables:

There are 10398 (Regular- 6569, contractual-3829) Staff Nurses working in the state. In the FY 2014-15, it is planned to train around 600 Staff Nurses (both contractual & regular) in 200 batches from delivery points.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Training of Staff Nurses in SBA	200 batches	73730	147.46 Lakhs	A.9.3.1.3	

A.9.3.1.4 - Training of ANMs / LHV's (senior health assistant female) in SBA

It is a continued activity:

For ANMs/LHVs who are conducting deliveries will be trained at identified centers at district and sub district hospitals including Medical Colleges.

During the training, participants will be trained to:

- Provide quality care and counseling to the woman during antenatal, labour and postpartum period.
- Identify danger signs during pregnancy, labour, delivery and postpartum period along with the danger signs in newborn; provide supportive care prior to referral.
- Monitor labour using partograph.
- Practice active management of third stage of labour.
- Follow routine infection prevention practices during pregnancy and child birth.

Training sites - DTCs/HFWTCs, District hospitals and sub district hospitals including Medical Colleges.

Trainers - SBA TOTs

Trainees - ANMs/LHVs

Batch size - 3-4 per Batch depends on delivery load.

Duration - 21 days (6 Days class room teaching and 15 days hospital posting.)

Achievement: Up to Feb 2014 totally 3607 ANMs/LHVs are trained inSBA training.

Financial Year	2011-12		2012-13		2013-14 (Apr 2013- Feb2014)	
Target/Achievement	Targ et	Achievem ent	Targ et	Achievem ent	Targ et	Achievem ent
	1000	756	600	468	600	340

Justification:

The training will enhance knowledge, confidence and skills for early identification of basic complications during pregnancy, childbirth as well as during post-partum period.

Deliverables:

There are totally 9875 ANMs (8931), LHVs (944) In the FY 2014-15, it is planned to train around 600 ANMs/LHVs in 200 batches.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Training of ANMs / LHVs (senior health assistant female) in SBA	200 Batches	73730	147.46 Lakhs	A.9.3.1.4	

A.9.3.2.3 -Training of Medical Officers in EmOC

It is a continued activity:

GOI through a PPP with FOGSI came up with a unique program called EmOC training through which excellence centers for EmOC will be set up and these centers will serve as EmOC training sites for medical officers working in the FRUs.

During the training the participants will be trained in the following

- Early identification of high risk pregnancy and timely interventions
- Parenteral antibiotics
- Parenteral oxytocics
- Parenteral anti-convulsants and anti-hypertensives
- Manual removal of placenta
- Removal of retained products (MVA)
- Assisted vaginal delivery (forceps, vacuum extraction)
- Blood transfusion
- Cesarean section

Training sites –Medical Colleges.

Trainers –TOTsMedical Colleges.

Trainees –In serviceMedical Officers.

Batch size – 8 Medical officers per batch.

Duration – 16 weeks (6 weeks in medical college 9 weeks in district hospital, last week for examinations).

Achievement: Totally 70 medical officers are trained in EmOC

Financial Year	2011-12		2012-13		2013-14 (Apr 2013- Feb2014)	
Target/Achievement	Targ et	Achievem ent	Targ et	Achievem ent	Targ et	Achievem ent
	20	9	16	6	16	0

Justification:

The critical bottlenecks for providing emergency obstetric care is serious shortage of specialists, so most of the facilities are not providing EmOC services to women with complications of pregnancy and child birth.

Deliverables:

Medical officers working in remaining FRUs where there are no specialists. In the FY 2014-15 it is planned to train 1 batch.

Funding proposed:

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Training of Medical Officers in EmOC	1	650000	6.50 Lakhs	A.9.3.2.3	Annexure attached

A.9.3.3.3 - Training of Medical Officers in Life Saving Anaesthesia Skills (LSAS)**It is a continued activity:**

In service regular MBBS doctors are identified and trained for a period of 18 weeks at identified training sites.

During the training the participants will be trained in the following

- Laryngeal mask airway Insertion
- Endotracheal Intubations and Extubation
- Lumbar Puncture & Spinal Anaesthesia

Training sites -Identified Medical Colleges and District hospitals.

Trainers - Faculty Medical College (Anesthetist).

Trainees - Medical Officers.

Batch size - 4 Medical officers per batch.

Duration - The total duration of the course will be 18 weeks. For 8 weeks trainees will be trained in the obstetrics emergency in the operation theatre and 4 weeks in general emergency at the casualty at identified hospital. The trainees will be sent to CHC for 2 weeks to complete their rural training. Than for 4 weeks the trainees will work in the selected district hospital under supervision.

Achievement: Totally 87 Medical Officers are trained in LSAS.

Financial Year	2011-12		2012-13		2013-14 (Apr 2013- Feb2014)	
Target/Achievement	Targ et	Achievem ent	Targ et	Achievem ent	Targ et	Achievem ent
	20	25	12	0	12	0

Justification:

The actual operationalization of FRUs is suffering due to lack of anesthetists. This is mainly due to no availability of anesthetists both Government and Private anesthetists. To fill up this critical gap it is planned to train MBBS doctors in anesthesia and thus they can handle the LSCS cases at the FRUs.

Deliverables:

The Medical Officers trained will be conducting LSCS & Emoc services at FRUs. In the FY 2014-15, it is proposed to train 2 batches

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Training of Medical Officers in life Saving Anaesthesia skills (LSAS)	2	600000	12.00 Lakhs	A.9.3.3.3	It is a continued activity due to policy matters LSAS was not conducted in the FY 2013-14

A.9.3.4.2 - Training of Medical Officers in Safe Abortion

It is a continued activity:

During the training, Medical Officers are trained in

- Legal aspects of abortion.
- To provide safe abortion services and to maintain optimum standards of care.
- To assist in strengthening the current available abortion care services and improving the overall quality of care.
- Use of vacuum aspiration techniques for medical termination of pregnancy.

Training sites - Identified medical colleges, both private and government.

Trainers - Gynecologists from Medical Colleges.

Batch size - 2 per batch.

Duration - 12 working days.

Achievement:

Financial Year	2011-12		2012-13		2013-14 (Apr 2013- Feb2014)	
Target/Achievement	Targ et	Achievem ent	Targ et	Achievem ent	Targ et	Achievem ent
	40	40	40	41	40	4

Justification:

Government of Karnataka is committed to increase access to safe abortion practices as an important strategy for reducing maternal mortality and morbidity.

Availability of safe abortion services to the woman is very essential at our health facilities. Different methods of safe abortion/comprehensive abortion care: medical method, MVA method and 2nd trimester abortion services are being taught and provided with required equipment after the training.

Deliverables:

It is proposed to train 50 MBBS doctors in 25 batches to provide comprehensive abortion care services at our health facilities.

Funding proposed:

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Training of Medical Officers in Safe Abortion	25 batches	26610	6.65 Lakhs	A.9.3.4.2	

A.9.3.6.2 - BEmOC training for MOs/LMOs

It is a continued activity:

During the training, the MOs are trained to -

- Provide quality antenatal care, intra-partum care, including monitoring of labour with partograph, active management of third stage of labour and postpartum care.
- Manage common obstetric problems such as anemia, hypertensive disorders of pregnancy including eclampsia, haemorrhage, abortion, puerperal sepsis, prolonged labour, preterm labour, foetal distress, prolapsed cord, twins, etc. and stabilize women before and during referral to the appropriate health facility.
- Do step wise practice on "essential newborn care" and take steps to ensure good health of the baby.
- Appropriately use steps to prevent infections during pregnancy, child birth and postpartum period.
- Make referral of complicated cases after initial management and stabilization.

Training sites – Identified medical colleges, both private and government.

Trainers – BEmOC trained TOTs

Batch size – 4 per Batch.

Duration – 10 days.

Achievement: Up to Feb 2014 totally 1099 Medical Officers were trained inBEmOC training.

Financial Year	2011-12		2012-13		2013-14 (Apr 2013-Feb2014)	
Target/Achievement	Target	Achievement	Target	Achievement	Target	Achievement
	500	592	400	243	252	116

Justification:

The purpose of this training is to enhance the capability of MBBS doctors posted at 24 x 7 PHCs and CHCs, so that they become proficient in identifying and managing basic obstetric complications and develop the necessary skills and competencies to provide essential obstetric and newborn care at the point of first contact with the client.

Deliverables:

There are 1050 24x7 PHCs and 324 CHCs , This year it is planned to train 252 MOs in 63 Batches.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	BEmOC Training for MO/LMO	63 batches	64100	40.38 Lakhs	A.9.3.6.2	

A.9.3.5.3, A.9.3.7.1 and A.9.3.7.2 Training of Medical Officers, Staff Nurses and ANMs in RTI/STI**It is a continued activity:**

Training sites – DTCs/HFWTCs.

Trainers – RTI/STI TOTs

Trainees – Medical Officers/ Staff Nurses/ANMs

Batch size – 30 for Medical Officers/ Staff Nurses/ANMs .

Duration – 2 Days.

Achievement:

Financial Year	2011-12		2012-13		2013-14 (Apr 2013-Feb2014)	
Target/Achievement	Target	Achievement	Target	Achievement	Target	Achievement
Training of Medical Officers in RTI/STI	300	275	500	247	300	198
Training of Staff Nurses in RTI/STI	2000	1564	1500	1446	1000	788
Training of ANM in RTI/STI	0	0	4500	398	1440	1984

Justification:

Sexually transmitted infections (STIs) present a huge burden of disease and adversely impacts reproductive health of people. Infections often go undiagnosed and untreated, and when left untreated, they lead to complications such as infertility; ectopic pregnancy and cervical cancer. To address this important public health problem it is necessary to train the health care providers in RTI/STI.

Deliverables:

After the training the trainees are expected –

- To screen asymptomatic especially contraceptives, ANC clients for STIs.
- Focus on prevention, with special reference to partner management, condom use, follow-ups and management of side effects.
- Provide counseling and testing services for HIV/AIDS and establish linkages with ART systems with respect to positives.

Funding proposed:

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Training of Medical Officers in RTI/STI	15	81900	12.29 Lakhs	A.9.3.5.3	
2	Training of Staff Nurses in RTI/STI	30	58910	17.67 Lakhs	A.9.3.7.1	
3	Training of ANM in RTI/STI	35	58910	20.62 Lakhs	A.9.3.7.2	

A.9.3.7.3 Training of AYUSH MOs in SBA**It is a new activity:**

One of the strategies of National Health Mission (NHM) is the mainstreaming of AYUSH doctors into the existing health care services delivery system. Based on the recommendations from an ICMR study on competencies of AYUSH doctors after SBA Training, it has been decided by the MOHFW that AYUSH doctors (Ayurveda and Homeopathy) posted at government health facilities may be permitted to conduct deliveries and provide basic treatment for complications before referral. Only those doctors who are posted at delivery points where ANC and PNC are conducted may be trained as SBAs.

They may be permitted for prescribing allopathic drugs for conducting normal deliveries including initial and basic management of complications before referral and can prescribe all those drugs permitted to ANMs and SNs after SBA training.

Justification:

The training will enhance knowledge, confidence and skills for early identification of basic complications during pregnancy, childbirth as well as during post-partum period.

During the training, participants will be trained to:

- Provide quality care and counseling to the woman during antenatal, natal and postpartum period.
- Identify danger signs during pregnancy, labour and postpartum period along with the danger signs in newborn; provide supportive care prior to referral.
- Monitor labour using partograph.
- Practice active management of third stage of labour.
- Follow routine infection prevention practices during pregnancy and child birth.

Training sites – DTCs/HFWTCs and identified district and sub district hospitals including Medical Colleges.

Trainers – SBA TOTs

Trainees – AYUSH MOs (Ayurveda and Homeopathy).

Batch size – 3 per Batch.

Duration – 28 days (6 Days class room teaching and 22 days hospital posting.)

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Training of AYUSH MOs in SBA	50	127310	63.66 Lakhs	A.9.3.7.3	As per GOI, MoHFW instructions

A.9.3.7.4 - Refresher Training in SBA Trained SNs/ANMs**It is a continued activity:**

This training programme helps the trainees to refresh their knowledge and skills in SBA

During the training, participants will be trained to:

- Provide quality care and counseling to the woman during antenatal, labour and postpartum period.
- Identify danger signs during pregnancy, labour, delivery and postpartum period along with the danger signs in newborn; provide supportive care prior to referral.
- Monitor labour using partograph.
- Practice active management of third stage of labour.
- Follow routine infection prevention practices during pregnancy and child birth.

Training sites – DTCs/HFWTCs.

Trainers – SBA TOTs

Trainees – SNs/ANMs/LHVs who have undergone regular SBA training

Batch size – 30 per batch .

Duration – 6 Days.

Achievement:

Financial Year	2011-12		2012-13		2013-14 (Apr 2013- Feb2014)	
Target/Achievement	Targ et	Achieveme nt	Targ et	Achieveme nt	Targ et	Achieveme nt
	3000	2887	2250	3071	2100	1609

Justification:

All the SBA trained staff nurses, district hospital staff nurses and ANM's will undergo refresher training in SBA as per the SBA training guidelines. This training programme helps the trainees to refresh their knowledge and skills to manage normal and complicated pregnancies.

Deliverables:

Up to Feb 2014 totally 7559 Staff Nurses/ANMs/LHVs were trained in SBA refresher training. This year it is planned to train 2100 SN/ANMs/LHVs in 70 batches who are working in district hospital and other delivery points.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Refresher Training in SBA Trained SNs/ANMs	70	155000	108.50 Lakhs	A.9.3.7.4	

A.9.3.7.5 -Refresher Training for EmOC trained MOs

It is a continued activity:

This training programme helps the trainees to refresh their knowledge and skills in EmOC.

During the training they are trained in.

- Early identification of high risk pregnancy and timely interventions
- Parenteral antibiotics
- Parenteral oxytocics
- Parenteral anti-convulsants and anti-hypertensives
- Manual removal of placenta
- Removal of retained products (MVA)
- Assisted vaginal delivery (forceps, vacuum extraction)
- Blood transfusion
- Cesarean section

Training sites – Identified training sites

Trainers – Master trainers

Trainees – Trained EmOC Medical Officers.

Batch size – 2 Medical officers per batch.

Duration – 1 Month

Achievement:

Financial Year	2013-14 (April - Feb)	
Target/Achievement	Target	Achievement
	20	0

Justification:

Most of the EmOC trained MOs are not confident in handling emergency LSCS due to various technical and administrative lapses. To enhance the skills of the EmOC trained MOs it is proposed to train 8 MOs in 1batch during 2014-15.

Deliverables: Totally 70 medical officers are trained in EmOC and these MOs need Refresher Training in EmOC.

Funding proposed:

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Refresher Training for EmOC trained MOs	5	55750	2.79 Lakhs	A.9.3.7.5	
2	To FOGSI for training of Mos	1	500000	5.00 Lakhs	A.9.3.7.9	

A.9.3.7.6 Skill Assessment for SNs/ANMs**It is a new activity**

Competency of health care providers in skills and knowledge is essential for quality health care outcome. Multiple assessment studies have shown that the competency levels of health care providers especially ANMs and SNs is suboptimal.

Justification:

Although services are being provided as per the numbers indicated in the HMIS the same is not translated into proportionate decrease in outcome indicators like IMR MMR etc. Hence a particular health functionary lacks competency/ has lower competency in a particular area, she/he will be provided competency enhancing training only in that thematic area after assessment.

Deliverables:

Service providers including contractual staff nurses from PHCs, CHCs, THs, DHs and major hospitals. This year it is planned to train 6000 service providers in 200 batches.

Funding proposed:

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Skill Assessment for SNs/ANMs	200	33630	67.26 Lakhs	A.9.3.7.6	

A.9.5 Child Health Trainings**Objectives:**

- To provide necessary skills & knowledge to the Medical officers and frontline health workers working at health facilities to reduce SBR, NMR, IMR, Under five mortality.

Strategies:

- To provide IMNCI skills in identifying danger signs of neonatal and childhood illnesses.
- IYCF training skills are provided to the frontline health workers and ASHA in providing home based new born care for neonate, young child and sick children.
- Medical officers and staff nurses of SNCU, PICU and NBSUs trained in FBNC helps in providing essential care for newborns and sick children at the facility level.

A.9.5.1.2- IMNCI training for ANM and LHV**It is a continued activity:**

Health workers will be trained in community based IMNCI in which home visits by health personal with parental participation in child rearing and referral service is given more importance. After training ANM and LHV utilize the skills and knowledge in their field practices to improve the awareness for the early identification of the danger signs of sepsis and other illness in new born and under 5 children. This helps in early referral to the health facilities for the proper management so that IMR and under 5 mortality can be reduced.

Training sites - DTCs/HFWTCs

Trainers - ToTs of IMNCI

Trainees - ANMs and LHVs

Batch size -30 persons per batch

Duration - 8 Days

Achievement: Up to Feb 2014 totally 8828 ANMs/LHVs were trained inIMNCItraining

Financial Year	2011-12		2012-13		2013-14 (Apr 2013-Feb2014)	
Target/Achievement	Target	Achievement	Target	Achievement	Target	Achievement
	3000	3286	2100	1131	1200	700

Justification:

The main objective of reducing the IMR and under 5 mortality rate is achieved by bringing it down to 32 & 37 respectively as per SRS 2012 data. Hence to achieve the 12th year plan and MDG of bringing down IMR to 25 it is proposed to continue this activity.

Deliverables:

There are 9875 (ANMs-8931, LHVs-944) ANMs/LHVs are working in the state and this year it is planned to train around 900 ANMs/LHVs in 30 batches.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	IMNCI training for ANM and LHV	30 batches	220000	66.00 Lakhs	A.9.5.1.2	

A.9.5.2.2 - F-IMNCI training for Medical officers

It is a continued activity:

Facility Based Integrated management of Neonatal and child hood Illness training will be imparted to medical officers working at health facilities, to manage the sick neonates and young children effectively. Medical officers utilize the skills and knowledge at the facility for the early identification of the danger signs of sepsis and other illness in new born & under 5 children for timely referral to the tertiary care facilities for further management.

Training sites - DTCs/HFWTCs

Trainers - ToTs of F-IMNCI

Trainees - Medical Officers

Batch size -20 persons per batch

Duration -11 Days

Achievement: Up to Feb 2014 totally 1425 Medical Officers were trained in F-IMNCI training.

Financial Year	2011-12		2012-13		2013-14 (Apr 2013-Feb 2014)	
Target/Achievement	Target	Achievement	Target	Achievement	Target	Achievement
	1000	779	1000	517	260	120

Justification:

The main objective is reducing the IMR and under 5 mortality rate is achieved by bringing it down to 32 & 37 respectively as per SRS 2012 data. Hence to achieve the 12th year plan and MDG of bringing down IMR to 25 it is proposed to continue this activity.

Deliverables:

Medical officers working at 24x7 PHCs/CHC/FRU will use their knowledge in management of sick new born and sick children. It is proposed for 15 batches during the FY 2014-15.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	F-IMNCI training for Medical officers	15 batches	297000	44.55 Lakhs	A.9.5.2.2	

A.9.5.2.3 - F-IMNCI training for Staff Nurse

It is a continued activity:

Facility Based Integrated management of Neonatal and child hood Illness training will be imparted to staff nurses working at health facilities, to utilize the skills and knowledge for the early identification of the danger signs of sepsis and other illness in new born & under 5 children for timely referral to the tertiary care facilities for further management.

Training sites - DTCs/HFWTCs

Trainers - ToTs of F-IMNCI

Trainees - Staff Nurses

Batch size -20 persons per batch

Duration -11 Days

Achievement: Up to Feb 2014 totally 3268 Staff Nurses were trained in F-IMNCI training

Financial Year	2011-12		2012-13		2013-14 (Apr 2013-Feb 2014)	
Target/Achievement	Targ et	Achievem ent	Targ et	Achievem ent	Targ et	Achievem ent
	2000	2380	2000	1034	500	341

Justification:

The main objective is reducing the IMR and under 5 mortality rate is achieved by bringing it down to 32 & 37 respectively as per SRS 2012 data. Hence to achieve the 12th year plan and MDG of bringing down IMR to 25 it is proposed to continue this activity.

Deliverables:

It is proposed for 25 batches during the FY 2014-15

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	F-IMNCI training for Staff Nurse	25	213000	53.25 Lakhs	A.9.5.2.3	

A.9.5.4.2 - SAM training for Medical officers

It is a continued activity:

SAM training is imparted to Medical officers, Staff Nurses and Diet counselors working at NRC's and MNRC's to identify and manage SAM children. The trained health personnel utilize the skills and knowledge in their practices in management of children with malnutrition & associated diseases. They also provide appropriate nutritional support including counseling to mothers.

Training sites – SIHFW with identified medical colleges

Trainers – ToTs of SAM

Trainees – Medical officers

Batch size – 30 persons per batch

Duration – 3 Days

Achievement: Up to Feb 2014 totally 145 Medical Officers/Staff Nurses/Diet Counselors were trained inSAM.

Financial Year	2012-13		2013-14 (Apr 2013-Mar2014)	
Target/Achievement	Target	Achievement	Target	Achievement
	60	49	30	37

Justification:

The main objective is reducing the IMR and under 5 mortality rate is achieved by bringing it down to 32 & 37 respectively as per SRS 2012 data. Hence to achieve the 12th year plan and MDG of bringing down IMR to 25 it is proposed to continue this activity.

Deliverables:

There are 57 NRC/MNRCs and each unit consists of 1 MO, 3 SNs and 1 Diet Counselor. This year it is planned to train 2 batches consisting of Medical Officers including paediatricians, staff nurses & diet counselors.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	SAM training for Medical officers	2 batches	171618	3.43 Lakhs	A.9.5.4.2	Including paediatricians, staff nurses & diet counselors.

A.9.5.5.1.2& A.9.5.5.1.3 – NSSK training for Medical officers and Staff Nurses.

It is a continued activity:

The NSSK training is imparted to medical officers& staff nurses in a combined batch. They will be trained in Neonatal Resuscitation Procedure (NRP), thermal regulation, prevention of Infection and early initiation of breast feeding and management of sick neonates and young children.

Training sites - DTCs/ HFWTCs

Trainers - ToTs of NSSK

Trainees - Medical officers and staff nurses

Batch size - 25 persons per batch (10 MOs & 15 SNs)

Duration - 2 Days

Achievement: Up to Feb 2014 totally 4548 Staff Nurses and 2033 Medical Officers were trained in NSSK training. There are 10398 Staff Nurses (Regular-6569, contractual-3829) and 2349 Medical Officers

Financial Year	2011-12		2012-13		2013-14 (Apr 2013-Feb2014)	
Target/Achievement	Target	Achievement	Target	Achievement	Target	Achievement
MOs	500	1492	1000	504	600	124
SNs	2500	2430	1000	1471	900	1260

Justification:

The NSSK trained health personnel utilize the skills and knowledge gained, in providing essential newborn care at birth and identification of danger signs & timely referral of the sick neonates to the higher centres.

Deliverables:

It is planned to train 600 MOs and 900 SNs for the FY 2014-15.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	NSSK training for Medical officers and Staff Nurses	60	66375	39.83 Lakhs	A.9.5.5.1.2& A.9.5.5.1.3	It is combined training for MOs and SNs and budget proposed under line item A.9.5.5.1.2

A.9.5.5.1.4 – NSSK training for ANM's

It is a continued activity:

The NSSK training is given to ANM's working at Sub Center. They will be trained in Neonatal Resuscitation Procedure, thermal regulation, early identification of Infection, and initiation of breast feeding and complimentary feeding.

Training sites - DTCs/ HFWTCs

Trainers - ToTs of NSSK

Trainees - ANMs

Batch size - 20 persons per batch

Duration - 2 Days

Achievement: Up to Feb 2014 totally 4329 ANMs were trained in NSSK training.

Financial Year	2011-12		2012-13		2013-14 (Apr 2013-Feb2014)	
Target/Achievement	Target	Achievement	Target	Achievement	Target	Achievement
	4500	1331	2000	1771	1500	1260

Justification:

The NSSK trained health personnel utilize the skills and knowledge gained, in providing essential new born care at birth and identification of danger signs & timely referral of the sick neonates to the facility.

Deliverables:

It is planned to train 2000 ANMs in 100 batches for the FY 2014-15.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	NSSK training for ANM's	100 batches	44500	44.50 Lakhs	A.9.5.5.1.4	

A.9.5.5.2.b – Refresher training on FBNC for Medical officers and staff nurses of SNCU

It is a continued activity:

The Medical officers and staff nurses are trained at identified medical colleges and institutions through SIHFW. After training in FBNC the Medical officers and staff nurses of district hospital SNCU will utilize the skills and knowledge in their practices in giving effective essential new born care at birth, managing low birth weight babies, premature babies, sick neonates discharged from the hospital except those requiring mechanical ventilation and surgical interventions. The refresher training will helps to boost their knowledge and skills.

Training sites - Identified Medical Colleges

Trainers - Paediatricians working in NICU

Trainees - Medical officers and staff nurses

Batch size - 6 persons per batch

Duration - 12 Days

Achievement: Up to Feb 2014 totally 89 SNs were trained in Refresher FBNC training

Financial Year	2013-14 (Apr 2013-Feb2014)	
Target/Achievement	Target	Achievement
	300	89

Justification:

To update the knowledge of the health personnel working at SNCU's with recent advances and techniques proposed by Government of India it is essential to give them refresher training.

Deliverables:

In this year it is planned to train 300 MOs/SNs for the FY 2014-15.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	2 weeks observership for facility based new born care	25 batches	93830	23.46 Lakhs	A.9.5.5.2.b	In FY 2013-14, it was projected in line item A.9.5.5.2.d

A.9.5.5.2.c - IYCF training for SN's, LHV's and ANM's

It is a continued activity:

Government of Karnataka as a pilot project started IYCF training program for the front line workers in 4 districts (One from each division i.e. Mysore, Kolar, Belgaum and Gulbarga). The IYCF training is given to ANM's, SN's and LHV's to provide optimal IYCF practices. This year it is planned to extend IYCF training to remaining 26 districts in a phased manner.

Training sites - DTCs/ HFWTCs

Trainers - ToTs of IYCF

Trainees - SNs, ANMs & LHVs

Batch size -30 persons per batch

Duration - 4 Days

Achievement: Up to Feb 2014 totally 628 SNs/ANMs/LHVs were trained in IYCF at 4 districts namely Mysore, Kolar, Belgaum and Gulbarga.

Financial Year	2013-14 (Apr 2013-Feb2014)	
Target/Achievement	Target	Achievement
	1800	628

Justification:

To promote the breast feeding practices at the earliest to enhance the knowledge and skills among expected mothers and to reduce IMR and under five mortality, it is very essential to train all the service providers in IYCF practices.

Deliverables:

There are totally 10398 SNs, 9875 ANM/LHVs (ANMs-8931,LHVs-944) are working in the state and this year it is planned to train 4500 SNs, ANMs/LHVs in 150 batches.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Training on IYCF to SNs/ANMs/LHV	150 batches	81050	121.58 Lakhs	A.9.5.5.2.c	

A.9.5.5.2.e – Regular training on FBNC for Medical officers and staff nurses of SNCU

It is a continued activity:

The Medical officers and staff nurses are trained in IGICH Bangalore which is a tertiary care unit through SIHFW. After training in FBNC of SNCU the Medical officers and staff nurses of district hospital SNCU will utilize the skills and knowledge in their practices in giving effective essential new born care at birth, managing low birth weight babies and sick neonates discharged from the hospital and except those requiring mechanical ventilation and surgical interventions.

Training sites – Indira Gandhi Institute of Child Health

Trainers – Staff of IGICH working in NICU

Trainees – Medical officers and staff nurses

Batch size –15 persons per batch

Duration – 60 Days

Achievement: Up to Feb 2014 totally 133 MOs and SNs are trained in FBNC training

Financial Year	2011-12		2012-13		2013-14 (Apr 2013-Feb 2014)	
Target/Achievement	Targ et	Achievem ent	Targ et	Achievem ent	Targ et	Achievem ent
	285	76	57	31	57	26

Justification:

To operationalize the SNCU of the District Hospital, Paediatrician/MOs and SNs are trained to manage sick new born and low birth weight / premature babies except those requiring mechanical and surgical interventions.

Deliverables:

It is planned to train 30 personnel in 2 batches for the FY 2014-15.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Regular training on FBNC for Medical officers and staff nurses of SNCU	2	1147890	22.96Lakhs	A.9.5.5.2.e	

A.9.6 Family Planning Programme

Objectives:

The objective of Family planning program is

- To upgrade the skills and knowledge of MBBS and specialist doctors, staff nurses and other health personnel in providing quality family planning services.
- To increase the pool of service providers through training and certification.

Strategies:

- Promotion of IUCD services with emphasis on PPIUCD.
- To increase the number of service providers in conducting laparoscopic tubectomy, minilap tubectomy, no scalpel vasectomy services.
- To promote counseling of clients, maintenance of quality and standards of operating procedures.
- To enhance the skills and knowledge of staff nurses and Jr. Health assistant Females/LHV's in providing the IUCD/PPIUCD services along with counseling and follow up services.

A.9.6.1.2- Laparoscopic Sterilization Training for doctors (Team of Doctor, SN and OT Assistant)

This is continued activity:

Laparoscopic Sterilization training for Gynecologists/General Surgeons and Staff Nurses and OT assistant is conducted as a team. These Gynecologist and Surgeons are also oriented about quality assurance in standard procedures in male and female sterilization technique. Trainees are trained as per the GOI norms in order to achieve proficiency as desired. This method is well accepted by the clients, since it needs short stay in the hospital.

Training sites – 3 Identified hospitals

Trainers – Trained gynecologists

Trainees – Gynecologists/General Surgeons and Staff Nurses and OT assistant.

Batch size – 3 per Batch

Duration – 12 working days.

Achievement: Totally 215 persons consisting of Gynecologists/General Surgeons, Staff Nurses and OT assistant are trained till Feb 2014.

Financial Year	2011-12		2012-13		2013-14 (Apr 2013- Feb2014)	
Target/Achievement	Targ et	Achievem ent	Targ et	Achievem ent	Targ et	Achievem ent
	60	41	30	30	150	39

Justification:

By increasing the pool of service providers at the Taluk/District levels, it helps to deliver the services at the right time and place which will reduce the client's waiting time. Hence it is proposed to continue this activity.

Deliverables:

It is proposed to train doctors and other health personnel in 40 batches for the FY 2014-15

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	- Laparoscopic Sterilization Training for doctors (Team of Doctor, SN and OT Assistant)	40	40895	16.36 Lakhs	A.9.6.1.2	

A.9.6.2.2 - Minilap training for Medical Officers

It is a continued activity:

MO's of 24x7 PHC's and CHC's along with staff nurses and OT assistant as a team are trained for 12 working days, at identified training sites. These Doctors are also trained in post partum sterilization technique.

Training sites – Identified training sites

Trainers – Trained gynecologists/Surgeon

Trainees – Medical Officers, Staff Nurses and OT assistant.

Batch size – 3 per Batch

Duration – 12 working days.

Totally 897 health personnel including Medical officers are trained.

These trained staffs working at delivery points with OT facility are equipped to provide both interval and post partum sterilization.

Achievement:

Financial Year	2011-12		2012-13		2013-14 (Apr 2013-Feb2014)	
Target/Achievement	Target	Achievement	Target	Achievement	Target	Achievement
	135	105	36	97	120	75

Justification:

By increasing the pool of service providers at the PHC/CHC/Taluk levels, it helps to deliver the services at the right time and place which will reduce the client's waiting time. Hence it is proposed to continue this activity.

Deliverables:

It is proposed to train 30 batches, one batch in each district for the FY 2014-15.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Minilap training for Medical Officers	30	27315	8.19 Lakhs	A.9.6.2.2	

A.9.6.3.2 NSV Training for Medical Officer**It is a continued activity:**

Medical officers of health facilities are trained for No Scalpel Vasectomy (NSV) done at the district level camps. This is budgeted under A.3

A.9.6.5.2 , A.9.6.5.4 and A.9.6.4.5 PPIUCD Insertion training for MOs , SNs and ANM/LHV**It is a continued activity:**

It is necessary for the field staff to be aware of the recent trends /concepts in family planning methods. Therefore it is planned to reorient the health personnel of health services, in IUCD/PPIUCD insertion techniques as per the GOI guidelines. The training will be imparted with help of the practice on ZOE models and as well as live case practice.

Training sites– Identified hospitals

Trainers - Trained gynecologists

Trainees - Medical Officers, Staff Nurses and ANM/LHV

Batch size - 10 per Batch

Duration - 5 working days (Those who have already trained in interval IUCD will be trained in PPIUCD for 3 days)

Achievement: Till Dec 2013 totally 1615 of MOs and 4503 of SNs are trained in IUCD this year it is planned to merge IUCD and PPIUCD and should be given for 5 days.

Financial Year	2013-14 (Apr 2013-Feb2014)	
Target/Achievement	Target	Achievement
MO	200	118
SNs	500	88

Justification:

By increasing the pool of service providers at the PHC/CHC/Taluk/DH levels, it helps to deliver the services at the right time and place which will reduce the client's waiting time. Hence it is proposed to continue this activity.

Deliverables:

It is proposed to train 75 batches of MOs, 75 batches of SNs and 300 batches of ANMs (10 per batch) for the FY 2014-15.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	PPIUCD Insertion training for MOs	75	72275	54.20 Lakhs	A.9.6.5.2	Those who have already trained in interval IUCD will be trained in PPIUCD for 3 days
2	PPIUCD Insertion training for SNs	75	53025	39.76 Lakhs	A.9.6.5.4	
3	PPIUCD Insertion training for ANM/LHV	300	53025	159.07 Lakhs	A.9.6.4.5	

A.9.6.8 Training of RMNCH+A/ F.P counsellors**It is a continued activity:**

RMNCH+A counselors have been recruited keeping in mind, the burden on the service providers not being able to give sufficient quality time in counseling the beneficiaries and the community. Government of Karnataka has recruited and trained these counselors posted at high delivery points to provide FW counseling services, RCH services and Adolescent services.

Training sites - SIHFW

Trainers - Trained gynecologists, pediatricians and Communication specialists.

Trainees - F P Counselors.

Batch size - 20 per Batch

Duration - 4 working days

Achievement:

Financial Year	2013-14 (Apr 2013-Mar2014)	
Target/Achievement	Target	Achievement
	40	29

Justification:

To ease the burden of service providers and create awareness of RMNCH+A services for better utility it is proposed to recruit and train another 40 RMNCH+A counselors at high delivery points.

Deliverables:

40 RMNCH+A counselors after the selection will be trained at SIHFW in 2 batches of 20 per batch.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Training of RMNCH+A/ F.P counsellors	2	129900	2.60Lakhs	A.9.6.8	

A.9.8.4 Other Trainings**A.9.8.4.3 Continuing Medical and Nursing Education: to new recruit MOs (Induction)****It is a continued activity:**

All the newly recruited MOs (Regular and contractual) need to be oriented in the implementation of National programs and management of health facilities.

- Training sites** – HFWTCs
Trainers – TOTs/ Resource persons
Trainees – Newly recruit MOs (Regular and Contractual)
Batch size – 30 per Batch
Duration – 5 days

Achievement: Up to Feb 2014 totally 560 MOs are trained in Induction training

Financial Year	2011-12		2012-13		2013-14 (Apr 2013-Feb2014)	
Target/Achievement	Targ et	Achievem ent	Targ et	Achievem ent	Targ et	Achievem ent
	0	0	500	253	480	307

Justification:

For achieving the expected health outcomes, it is very essential to orient / train our newly recruited MOs.

Deliverables:

It is planned to train 450 MOs in 15 batches for the FY 2014-15.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Continuing Medical and Nursing Education: to new recruit MOs (Induction)	8	200000	16.00 Lakhs	A.9.8.4.3	

A.9.11.3 -Other Training and capacity building Programmes (Nursing Tutors etc.)

Certificate Course in Public Health Nursing (CPHN)

It is a continued activity:

Effective implementation of preventive & curative services in the community by health care providers, need continuous monitoring & supervision. At present, there is a shortage of public health nursing supervisory cadre with DPHN qualification. To bridge this gap and to enable the supervisory staff already working as LHV's to be promoted, as Nursing Superintendent Grade II, Grade I, at different levels i.e district and taluka health offices, at Training centers of ANM's, LHV's and HFWTC/DTC.

SIHFW under NRHM commenced CPHN course, for a batch of 25 students, from the F Y 2011-12, which aims at preparing teachers and administrators in Community Health & Community Health Nursing.

Training site – SIHFW

Trainers – Faculty of CPHN

Trainees – Senior Health Assistant (F) [LHVs] of H & FW Dept.

Batch size – 30 per Batch

Duration – Compulsory residential course of 18 months in 3 semesters

First batch of 25 Senior Health Assistant (Female) have completed the course in the F Y 2012-13, and they are working at their parent health facilities as the process of promotion to the next cadre is under consideration/Process.

Achievement:

Financial Year	2011-12		2012-13		2013-14 (Apr 2013-Feb2014)	
Target/Achievement	Targ et	Achievem ent	Targ et	Achievem ent	Targ et	Achievem ent
	25			25	30	Ongoing (24)

Justification:

As there is a dire need for trained district level public health supervisory staff both at district administration and training institutes. Hence this activity is proposed for continuation. At present 4 labs required for CPHN course is running in One cubicle with equipments packed therefore construction and establishing of 2 additional labs required is under process by KHSDRP along with purchase of books required for library upgradation.

Deliverables:

Already 25 trained health personnel's are in the field at different capacities and another 24 are undergoing training which is completing in Sep-2014.

Funding is proposed

Sl No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Other Training and capacity building Programmes (Nursing Tutors etc.) Certificate Course in Public Health Nursing (CPHN)	1	5200000	52.00 Lakhs	A.9.11.3	
2	Establishment of 2 additional labs with equipments and library which is mandatory for CPHN Course	1	3000000	30.00 Lakhs		
	Total			82.00 Lakhs		

A.9.11.3.1 –PGDHM - Distance Learning Courses

It is a new activity Proposed by NIHFW:

To build the capacity of frontline professionals like MOs, Program Officers and paramedical staff in management and functioning of the health facilities at different levels, SIHFW has taken the initiative to conduct distance learning courses.

(a) Post Graduate Certificate Course in Hospital Management for Medical Officers.

Most of our government health facilities are under developed & poorly managed and lack modern diagnostic and therapeutic equipments, proper emergency services, critical care areas, essential pharmaceuticals and supplies, referral support and resources, laundry, dietary, nursing services etc. High hospital infection rates and death rates are very common. One reason may be that Hospital Management is yet to be recognized as an important specialty. Further, there is hardly any hospital policy for the management of the government hospitals, which not only adversely affects patient care but also leads to a situation of crisis every now and then. To overcome this crisis, the hospital authorities resort to ad-hoc solutions. Their approach remains what is more commonly known as management by crisis.

In view of the above, there is an urgent need to train the concerned people in the hospitals to improve the management and functioning of the hospitals.

Training site – SIHFW

Trainers – Faculty of NIHFW/SIHFW

Trainees – Medical Officers of H & FW Dept. & Ayush Dept.

Batch size – 30 per Batch

Duration – 1 year

(b) Post Graduate Certificate Course in Health & Family Welfare for Staff Nurses & Pharmacists

With the adoption of the new strategy of delivering both Health and Family Welfare Services as an integrated package, there has been a growing recognition of the need to provide management education to health and family welfare personnel at all levels.

Training site – SIHFW

Trainers – Faculty of NIHFW/SIHFW

Trainees – Staff Nurses and Pharmacists.

Batch size – 30 per Batch

Duration – 1 year

(c) Diploma in Health Promotion for other Para-Medical Staff

In order to build the capacity of frontline professionals in health promotion, the State Institute of Health and Family Welfare (SIHFW) is conducting the one year 'Diploma Course in Health Promotion' through distance learning. The aim of this course is to build the capacity of paramedical, and other stakeholders concerned with the health of the society across the sectors in aspects related to health promotion. The trained personnel in health promotion would greatly help in reducing the double burden of communicable and non-communicable diseases in India, through management of lifestyles by promoting healthy diet, physical activity, stress management, reduction of tobacco / substance abuse and alcohol towards achieving healthy approach to life.

Training site – SIHFW

Trainers – Faculty of NIHFW/SIHFW

Trainees – Other Para Medical Staff of H & FW Dept.

Batch size – 30 per Batch

Duration – 1 year

(30 Participants for each course (a), (b), (c) - Rs. 21000x90)

Funding is proposed

Sl No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	Distance Learning Courses	3	630000	18.90	A.9.11.3.1	This is a New Activity proposed by NIHFW

HOME BASED NEWBORN CARE (HBNC)

It is a continued activity:

HBNC training program is mainly aimed to build the capacity of ASHAs for providing the essential skills for birth preparedness, routine new born care, supporting breastfeeding, common issues in the newborns apart from the illnesses, identifying the common danger signs in newborns and mothers, early referral, counseling the mother and family on birth spacing, immunization, etc. there by reducing the IMR and MMR.

Training sites – DTCs/HFWTCs and Identified Taluka hospitals

Trainers – ASHA mentors who have undergone the TOTs

Trainees – ASHA's who have completed the basic ASHA training

Batch size – 30 per Batch

Duration – 20 days

B1.1.1.2 HBNC training is given in Two patterns

- HBNC Training of ASHA 6 & 7 Module of GOI Pattern
- HBNC Training of Gadchiroli pattern

1) HBNC Training of ASHA 6 & 7 Module of GOI Pattern

The care of the ANC, new born and postnatal mother is very essential. In order to support ANMs, ASHAs are trained in this program for 20 days (2 workshops of 10 days duration each) as per GOI guidelines in cascading model. In this, 6 post natal visits by the ASHAs are mandatory.

CONTENTS OF ASHA MODULE TRAINING (6 & 7)

Round 1 & 2 - duration: 10 days

- Introduction to ASHA 6 & 7 module:
Role of ASHA, essential skills about management of new born, Home visit, VHND
- Maternal health:
 1. Confirmation of pregnancy
 2. Planning for safe delivery
 3. Anaemia
 4. Complication during pregnancy & delivery
 5. Care during delivery & post delivery
 6. Planning of home visits

Round 3 & 4- duration: 10 days

1. Child health & nutrition
2. Women's reproductive health
3. Newborn health
4. Introduction to infectious diseases
5. Filling of forms

2) HBNC training of Gadchiroli pattern (Model)

Home based Newborn Care of Gadchiroli pattern is followed in 7 'C' category & Chamarajanagar districts. The HBNC training of Gadchiroli pattern does not include the Care of child from 2 months to 5 years, Reproductive health (family welfare methods), Control of communicable diseases – especially Malaria, Tuberculosis & HIV/AIDS. These topics are included in round 5. We have not adopted the practicing of Ambu bag and administration of injection Gentamycin & Vitamin-K of Gadchiroli pattern.

Contents of round 1 & 2: Duration 8 days

- Introduction to HBNC programme
- Local practices about pregnancy, delivery and new born care
- Role of ASHA in HBNC programme
- IEC/BCC activities – using flip charts
- Calculating EDD on the basis of LMP
- Home visits to ANC & PNC and filling of forms
- Observation during delivery & new born care
- Time recording by using digital watch
- Weighing of new born

Contents of round 3 & 4: Duration 6 days

- Identification of high risk new born & its management
- Breast feeding
- Filling of home visiting forms

- New born resuscitation using mucus sucker
- IEC/BCC activities using flip charts
- How & when to refer the sick child
- Keeping the baby warm
- Planning of home visits etc.,

Contents of round 5: Duration 6 days

- Care of child from 2 months to 5 years
- Reproductive health (family welfare methods)
- Control of communicable diseases – especially Malaria, Tuberculosis & HIV/AIDS.

HBNC Training		
Rounds	ASHA 6 & 7 GOI Pattern	Gadchiroli Pattern
Round 1 & 2	10 days	8 Days
Round 3 & 4	10 days	6 Days
Round 5	-	6 Days

Total no. of ASHA's functioning in the state are 30175

1) **No. of ASHA's Trained in Round 1 & 2 upto Feb 2014** – 29751

Balance- 424 to be trained

Newly selected ASHA's – 3950+1530(urban)= 5880

Target for the F Y 2014-15 – 3950+424+1530 = 5904 (in 197 Batches)

2) **No. of ASHA's Trained in Round 3 & 4 upto Feb 2014** – 27306

Balance – 2869 to be trained

Newly selected ASHA's – 3950+1530(urban) = 5880

Target for the F Y 2014-15 – 3950+2200+1530 = 7680 (in 256 Batches)

3) **No. of ASHA's Trained in Round 5 upto Feb 2014** – 7146 (Out of 8098 of C category Dist.)

Balance- 952 to be trained

Newly selected ASHA's – 570

Target for the F Y 2014-15 – 570+700 = 1270 (in 43 Batches)

Total No.of ASHA's to be trained:

Round 1&2 : 5904 (in 197 Batches)

Round 3&4 : 7680 (in 256 Batches)

Round 5 : 1270 (in 43 Batches)

14854 ASHA's to be trained in 496 Batches.

Justification:

ASHAs who are already in the field trained in basic modules are to be equipped with the basic child health management for which HBNC training is very essential.

Deliverables:

Taking care of the new born and the child in the development and in sickness.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1.	ASHA Training Module 6 & 7	496	182650	905.94 Lakhs	B1.1.1.2	

A..9.5.5.2.dHBNC Training for ANMs

It is a continued activity:

ANMs are also sensitized in HBNC training for 5 days to supervise ASHAs in the field. It is an ongoing activity. Upto March 2013 totally 6739 ANMs were sensitized in HBNC training, which was not planned in the F Y 2013-14. Now it is planned to sensitize 2500 ANMs in HBNC training in the F Y 2014-15.

Training sites – DTCs/HFWTCs

Trainers – ASHA mentors who have undergone the TOTs

Trainees – ANMs

Batch size – 50 per Batch

Duration – 5 days

Achievement:

Financial Year	2011-12	2012-13	2013-14 (Apr 2013-Feb2014)
Target/Achievement	Achievement	Achievement	Achievement
	2320	2948	0

Justification:

ANMs who are the immediate supervisor staff for the ASHAs need to be oriented to supervise and assist them in the field. Therefore this activity is proposed for continuation.

Deliverables:

Around 6739 ANMs who are trained are monitoring and assisting ASHAs in the field. It is proposed to train another 2500 ANMs for the year 2014-15. Hence the activity proposed for continuation.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1.	HBNC Training for ANMs	50	170300	85.15 Lakhs	A..9.5.5.2.d	

B1.1.2.4 ASHA HBNC New Kits**It is a continued activity:**

The ASHA HBNC kits consists of essential equipment's required to assist the ASHA in taking care of the new born / child in the field.

HBNC Kit consists of:

- 1) Spring weighing balance
- 2) Digital thermometer
- 3) Digital wrist watch &
- 4) Baby warmer bag

Achievements:

Total No. of ASHA's : 30175

Total No. of HBNC kits given to ASHA's : 29903

Total No. of HBNC kits needed for the F Y 2014-15 : 3000 +1600 (urban) = 4600 (For newly recruited ASHAs)

Cost per unit : 1100

Justification:

The HBNC kits given to ASHA (29903) are helping them to manage the HBNC activity in the field. Hence it is very essential to provide the kits to the remaining ASHAs who are to be trained

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	ASHA HBNC New Kits	4600	1100	50.60 Lakhs	B1.1.2.3.1	

Details of Vacant Posts of Health Education Officers (HEOs) & District Nursing Officers (DNOs) & required Computer Operators at DTCs and HFWTCs										
A.9.2.2.2 SI.No. 4						Annexure-I				
Sl. No.	DTC/HFW TC	HEO				DNO				Computer Operator
		Vacant	Contractual working		Remark	Vacant	Contractual working		Remark	Contractual staffs to be continued /appointed
1	Ramanagara	1	1	A.P. Pattanshetti	To be continued	1	0		To be appointed	1
2	Belgaum	1	1	M.B.Sangolli	To be continued	1	0		To be appointed	1
3	Bellary	1	1	Dvelae Jadav	To be continued	1	0		To be appointed	1
4	Bidar	1	0		To be Appointed	1	1	Smt.Suhasini	To be continued	1
5	Bijapur	1	0		To be Appointed	1	1	Smt. S.V.Ramgundi	To be continued	1
6	Chickmagalur	1	0		To be Appointed	1	0		To be appointed	1
7	Chitradurga	1	1	Basavrai	To be continued	1	1	Manjula	To be continued	1
8	Mangalore	0	0			1	1	Smt.Chikki	To be continued	1
9	Dharwad	1	1	Talwar	To be continued	1	0		To be appointed	1
10	Gulbarga	1	1		To be Appointed	0	0			1
11	Hassan	0	0			1	0		To be appointed	1
12	Madikeri	1	0		To be Appointed	0	0			1
13	Kolar	1	1	S.M.Venkataram.S	To be continued	1	1	G.Kasturi	To be continued	1

14	Mandya	1	1	Nagaraj	To be continued	1	1	Smt.Shivaganga bike	To be continued	1
15	Mysore	1	1	P.M.Mayappa	To be continued	1	0		To be appointed	1
16	Raichur	1	0		To be Appointed	1	1	Smt.Suvrna.A	To be continued	1
17	Shimoga	1	1	N.Haridas mallya	To be continued	1	0		To be appointed	1
18	Tumkur	1	1	G.K Kulkarni	To be continued	0	0			1
19	Karwar	1	0		To be Appointed	1*	0		To be appointed	1
1	HFWTC Hubli	1	0		To be Appointed	1	1	K.B Hirejan	To be appointed	1
2	HFWTC Mysore	1	0		To be Appointed	1	0		To be appointed	1
3	HFWTC Gulbarga	1	1	Udupirao	To be continued	1	0		To be appointed	1
4	HFWTC Bangalore	1	0		To be Appointed	1	0		To be appointed	1
	SIHFW									2
	Total	21	12			20	8			25

*Present working DNO will be retiring on 31/05/2014

BUDGET REQUIREMENT OF ANMTC FOR THE YEAR 2014-15

(A.9.2.2.2) Sl.No. 7 Support to ANMTCs

Annexure-II

I. Human Resources (Contractual Staff appointment)				
A	For 9 ANMTCs (under NRHM)	No. of Units	Unit Cost	Amount
1	Additional teaching faculty	9x2=18	0.1	21.60
2	Data entry operators	9x1=09	0.1	10.80
3	Cooks	9x2=18	0.085	18.36
4	Assistant cooks	9x1=09	0.082	8.86
5	Drivers	9x1=09	0.082	8.86
6	Group-D (1 Security)	9x1=09	0.075	8.10
				76.58
B	For 19 ANMTCs (under State)	No. of Units	Unit Cost	Amount
1	Additional teaching faculty	19x2=38	0.1	45.60
2	Data entry operators	19x1=19	0.1	22.80
3	Cooks	19x2=38	0.085	38.76
4	Assistant cooks	19x1=19	0.082	18.70
5	Drivers	19x1=19	0.082	18.70
6	Group-D (1 Security)	19x1=19	0.075	17.10
				161.66
II	Field visits:			
a	Provision of lend for accommodation of students during their field visit (3 months) for 30/40 student	28x3=84	0.12	10.08
b	Mobility support:			

	1	POL support for the vehicles of 09 ANM centres (60000 per year)	09x1=09	0.75	6.75
	2	Hiring of vehicles of 19 ANM centres (per year Rs. 1,20,000) (for 3 months community health field postings)	19x3=57	1.2	22.80
				Total	39.63
III	Office Maintenance for 9 ANMTC:				
	A	Office maintainance for 9 ANMTC	09x1=09	1.8	16.20
	B	Electricity, water, LPG and others	09x1=09	4.2	37.80
				Total	54
IV	Conducting examinations:				
	A	Printing of answer booklets & question papers (1 regular exam and 1 supplementry exam) ANMTC			
		1) 1000 students x 2 booklets=2000			
		2) Supplementary - appr. Booklets=1000	3000	0.0005	1.5
		Per question paper & answer booklets - Rs.50/-			
	B	Paper valuation:			
		a) Valuers (Rs.20 per paper) 3000*20			
		2000+1000 =3000 papers	3000	0.0002	0.6
		b) Tabulation			
		2000+1000=3000 papers	3000	0.0001	0.3
		c)Printing of Marks Cards (1000*100)	1000	0.001	1
		d) Printing of Certificates (1000*75)	1000	0.00075	0.75
	C	Honorarium (ANMTC)			
		AT SIHFW			
		1) Chairman(Director)4+2=6days	1x6	0.01	0.06
		2) Co-Chairman(J.D)4+2=6days	1x6	0.01	0.06

	3) Pro. manger(D.D)4+2=6days	1x6	0.01	0.06
	4)Superintendent(A.D (PHN)4+2=6days	1x6	0.005	0.03
	5) Clerical staff 2x4days=8	8	0.003	0.024
	6)Data entry operators : 2x4days=8	8	0.002	0.016
	7) Group-D 10x4days=40	40	0.001	0.004
	At ANMTC CENTRES			
	1. Custodian (ANMTC Principal) 28x4days=112	112	0.005	0.56
	2. Invigilators (Tutors) 28x2days=56	56	0.003	0.168
	3. Examinination(int&Ext) 28x(2+2)x112	112	0.003	0.336
	4.Exam squad (DHOs)28 units 28x2days	56	0.005	0.28
D	Prining Booklets/question paper (LHVTCs)			
	1.120 Studentsx3 (360+40)	400	0.0005	0.2
	Per question paper & answer booklets - Rs.50/-			
	2. Papar Valuation 360x20	360	0.0002	0.072
	3.Tabulation 360x10	360	0.0001	0.036
	4. Certificates 120x75	120	0.0008	0.096
E	Supervising Honorarium(LHVTC)			
	AT SIHFW			
	1) Chairman(Director) 5+2=7	1x7=7	0.01	0.07
	2) Co-Chairman(J.D) 5+2=7	1x7=7	0.01	0.07
	3) Pro. manger(D.D) 5+2=7	1x7=7	0.01	0.07
	4)Superitadend(A.D CPHS)5+2=7	1x7=7	0.005	0.035
	5) Off. Attd 2x5=10	10	0.003	0.03
	6)Data entry operators : 2x5=10	10	0.002	0.02
	7) Group-D 10x5=50	50	0.001	0.05

		At LHVTC			
		1. Custodian (LHVTC Principal) $4 \times (3+2) = 4 \times 5 = 20$	20	0.005	0.1
		2. Invigilators (Tutors) $4 \times 3 = 12$	12	0.003	0.036
		3. Examination(int&Ext) $4 \times 2 \times 2$	16	0.003	0.048
		4.Exam squad (DHOs) 3×4	12	0.005	0.06
					6.741
V	ANMTC and LHVTC section office expenses: (examinations, question paper printing, answer booklets printing, packing materials & other expenses)		2	1	2
VI	ANMTC and LHVTC Principals review meeting		2	0.5	1
			Grand total		
			I	A	76.58
				B	161.66
			II		39.63
			III		54
			IV		6.741
			V		2
			VI		1
				Total	341.61

Annexure – III

Annual budget for Internal Quality Assurance Cell

S.No	Purpose of grant	Amount (in INR)
1	Technical officer @ 40000*6	240000
2	Office assistant (Secretarial services) @	120000

	20000*6	
3	Office Equipments (Computer, printer phone)	100000
4	Communication expense@ 5000*6	30000
5	Contingencies @ 3000*6	18000
	TOTAL	508000

	Annexure – IV						
Infrastructure Requirement for Implementing of Training Database Software							
1	Infrastructure Details						
	Item	Quantity	Tentative Cost per Unit (INR)	Tentative Total Costs(INR)	Resource		
					Available	Needed	
1.1	PC with Internet Facility	1	50,000.00	50,000.00		1	
1.2	Internet connection for PC (per annum)	1	5000	5000		1	
1.3	Stationary items			5000		Rs. 5000	
1.4	Furniture	1 Set	25000	25,000.00		1 Set	
1.5	Room Rent					0	
2	Human Resource Details						
2.1	M&E Training Officer (based either at State SIHFW or at State NRHM/SPMU office)	1	60,000 per month	60000 X 6 = 360000	Any Post Graduate with minimum of 2 years experience in health domain in context of management, development and conduction of training		
			Total	360,000.00			1
			Total	440,000.00			

Annexure V

Infrastructure Requirement at each district for Implementing of Training Database Software						
1	Infrastructure Details					
	Item	Quantity	Tentative Cost per Unit (INR)	Tentative Total Costs(INR)	Resource	
					Available	Needed
1.1	PC with Internet Facility	23	50,000.00	11,50,000		23
1.2	Internet connection for PC (per annum)	23	5000	1,15,000		23
1.3	Stationary items			46,000		Rs. 46000
1.4	Furniture	23 Sets	20000	4,60,000		23
1.5	Room Rent					0
			Total	17,71,000		
2	Human Resource Details				Qualification	
Quantity	Item	Quantity	Tentative Cost per Unit (INR)	Tentative Total Costs(INR)		
2.1	If Required:					
	Junior programme manager	23	22,000 per month	30,36,000.00	Graduate, Diploma in Computers and atleast 1 year exp. In Health Domain	
			Total	48,07,000.00		

				Annexure VI					
Checklist for operationalising E-learning Courses in the states									
Infrastructure Requirements at each SIHFW for Implementing E-learning Courses									
			Item	Desired Quantit y	Tentative Cost per Unit (INR)	Tentative Total Costs	Requirement		Cost
							Availabl e	Neede d	
1	Learning Infrastructure Details for participants taking course at SIHFW location								
		a)	Training Room Including Furniture	1		20,00,000.00		1	
		b)	Screen	1	15,000.00	15,000.00		1	
		c)	PC Projector	1	100,000.00	100,000.00		1	
		d)	PC with Internet Facility to be connected with Projector	1	50,000.00	50,000.00		1	
		e)	Internet enabled Multimedia ready PCs	15	30,000.00	4,50,000.00		15	
		f)	Headsets	15	500.00	7,500.00		15	
		g)	Dedicated Leased Line (atleast 1 Mbps)	1	300,000.00	3,00,000.00		1	
2	Mentor Infrastructure for taking Live Class								
		a)	Internet enabled Multimedia PC with Camera and Mic	1	60,000.00	60,000.00		1	
		b)	High Speed Internet (1 MBps dedicated connection) per annum	1	30,000.00	30,000.00		1	
			Total			3,012,500.00			

PGDPHM course for in service Doctors

Activity proposed:

Public Health Management course for Medical Officers and Nurses of the department of Health and Family Welfare & Department of AYUSH:

Name of the activity

One year post graduate diploma in Public Health Management.

Whether new or being continued

It is a continued activity.

Achievements:

First batch of 30 medical officers has completed the course in 2012-13 and have been posted as program officers like Deputy Directors, DPMO, DSO, Taluka Health Officers (Block health Officers).

The second batch of 36 medical officers (29 H&FW dept, 1 from AYUSH and 1 from ESI) are undergoing the post graduate diploma in public health management course. The batch is scheduled to complete the course in Aug 2014.

Justification

Knowledge commission of India, Planning Commission of India, NRHM & Ministry of Health GOI & Knowledge commission of Karnataka have all analysed and advocated the need to strengthen Public Health and the creation of a Public Health Cadre.

As per GOI letter D.O.No.P.12020/1/2013-NRHM-IV dated January 15, 2013 from Joint Secretary the said programme is proposed accordingly. H&FW Department Govt. of Karnataka has assessed the need for public health specialists in the state as about six hundred thirty (630) public health specialists have been trained and have been posted as programme officers. 36 Medical Officers will complete the PGDPHM course by August 2014. It is proposed to train 40-50 medical officers per year in PGDPHM course to address the shortfall of public health specialists in the state.

The state of Karnataka in addition deputed medical officers for MD Community medicine, DPH and MPH Courses in limited numbers to various institutions from its own resources.

Department of Health and family welfare has formulated draft public health cadre rules which are under active consideration of the department.

Deliverables:

40-50 public health specialists (trained medical officers per year) for placement as Taluka Health Officers (Block Health Officers), Programme Officers at districts level and programme managers at state levels.

Funding proposed

No of Units	Cost Per unit	Total Cost	FMR Code
40	2,75,000.00	110,00,000.00	A.9.11.3.1

PGDHEP course for in service Doctors / Staff nurse**Activity proposed:**

Post graduate diploma in Health Economic, Health Care Financing and Health Policy (PGDHEP)

Name of the activity:

One year post graduate diploma in Health Economic, Health Care Financing and Health Policy (PGDHEP)

Whether new or being continued

It is a new activity.

Justification

There is need for introducing concepts in Public Health and policy, Basic Research Methods in health, as also applications of Economic Evaluation, Health care financing, Health Planning, Health Policy, Health Systems and pharmaceutical economic to middle level manager for capacity building of public Health manager of the department of Health and Family welfare services, Government of Karnataka.

Deliverables:

Three in-service candidates, in-service doctors, nurses, AYUSH and Dental doctors are eligible for deputations.

Funding proposed

No of Units	Cost Per unit	Total Cost	FMR Code
3	2,25,000.00	6,75,000.00	A. 9.8.4.5

MPH course for in service Doctors / Staff nurse

Activity proposed:

Master of Public health.

Name of the activity:

Master of Public Health course for in service Doctors.

Whether new or being continued

It is a new activity.

Justification

Knowledge commission of India, Planning Commission of India, NRHM & Ministry of Health GOI & Knowledge commission of Karnataka have all analysed and advocated the need to strengthen Public Health and the creation of a Public Health Cadre.

H&FW Department Govt. of Karnataka has assessed the need for public health specialists in the state as about six hundred thirty (630) public health specialists have been trained and have been posted as programme officers. 36 Medical Officers will complete the PGDPHM course by August 2014 and 5 MPH candidates are completing the course during this 2013-14. It is proposed to depute 5 in-service doctors for MPH courses to address the shortfall of public health specialists in the state.

Department of Health and family welfare has formulated draft public health cadre rules which are under active consideration of the department. Need for expertise Public Health Services. Hence this activity is proposed

Deliverables:

Two candidates from In-service Allopathic Doctors for deputation.

Funding proposed

Sl. No.	Name of the activity	No. of Units	Cost per unit	Total Cost	FMR Code
1	MPH course at NIMHANS and other institutions	5	2.50 lakhs	12.50	A. 9.8.4.5
2	MPH honors at Rajiv Gandhi university (3 year courses)	5	2.50 lakhs	12.50	A. 9.8.4.5

Deputation for Short-term Training courses

Activity proposed:

Short-term Training Course for doctors, staff nurses and other staffs.

Name of the activity:

Deputation for Short-term Training Course at reputed training centers in India.

Whether new or being continued

It is a new activity.

Justification

Various courses are conducted to improve the performance of the working staff at various training institutions in India. In order to improve the quality of health care services doctors, staff nurse and other staff working are to be trained to upgrading the skills, knowledge & recent advances which will reflect in the outcome of the work.

Deliverables:

It is proposed to depute around 50 candidates for various recognised trainings in the reputed institutions in India.

Funding proposed

No. of Units	Cost per unit	Total Cost	FMR Code
50	20,000/-	10.00 lakhs	9.8.4.5

A.10. Programme Management

Programme Management at state level (A.10.1):

Proposal to augment the capacity of State Programme Management

Unit in National Health Mission (NHM) Karnataka: A.10.1.5

The State Programme Management Unit (SPMU) Under NHM in Karnataka has a total strength of 1028 most of which comprised of staff such as programme assistants, data entry operators, drivers and group D etc.

1. Maternal Health Division:

The Maternal Health Division looked after by a regular officer of Deputy Director Rank from the State Health & Family Welfare Department. A technical expertise and programme monitoring capacity the following posts are proposed in the MH Division:

- Technical Advisor-(Maternal Health)
- Consultant (Maternal Death Review, Safe Abortions, STI/RTI). Existing post will be re-designated as this new post.
- Consultant- (JSSK &JSY)
- Consultant- (Training-includingEMONC,BEMONC,SBA,LSAS etc.)

For the Technical Advisor, qualifications prescribed are MBBS with a post-graduation in OBG or PSM (MD or MPH). A minimum of 10 years of experience of Health Programme Management is required. Experience in the field of Maternal or Child Health would be desirable. (Salary Rs.70,000)

For Consultants qualifications prescribed are MBBS, BAMS, BHMS, BUMS, BDS or any other graduate with a post-graduation in Public Health (MPH) or Management (MBA) or post graduate diploma in Health Management. 3-5 years of experience in the field of Health Programme Management is required. Experience in the field of Maternal or Child Health would be desirable. (Salary Rs. 50,000)

2. Child Health Division:

This division is also being looked after by a regular officer of Deputy Director Rank from the Department of Health and Family Welfare. The following posts are proposed in order to strengthen the division:

- Technical Advisor-(Child Health)
- Consultant (Facility Based New Born Care-Existing Post would be re-designated as this)
- Consultant- (SAM/NRC/MNRC)
- Consultant- (Training-including IMNCI, FIMNCI, NSSK etc.)

For the Technical Advisor, qualifications prescribed are MBBS with a post graduation in Pediatrics or PSM (MD or MPH). A minimum of 10 years of experience of Health Programme Management is required.

Experience in the field of Maternal or Child Health would be desirable. (Salary Rs.70,000)

For Consultants qualifications prescribed are MBBS, BAMS, BHMS, BUMS, BDS or any other graduate with a post-graduation in Public Health (MD-PSM or MPH) or Management (MBA) or a post graduate diploma in Health Management. 3-5 years of experience in the field of Health Programme Management is required.

Experience in the field of Maternal or Child Health would be desirable. (Salary Rs. 50,000)

3. Immunization Division:

This is headed by a Deputy Director from DoHFW. There is no other regular technical staff or this crucial division. It is imperative that the division strengthened by technical consultants as follows:

- Consultants (Immunization, including Routine Immunization, Pulse Polio, AEFI Monitoring etc.)

For Consultant qualifications prescribed are MBBS, BAMS, BHMS, BUMS or any other graduate with a post-graduation in Public Health (MPH) or Management (MBA) or a post graduated diploma in Health Management. 3-5 years of experience in the field of Health Programme Management is required.

Experience in the field of Maternal or Child Health would be desirable. (Salary Rs. 50,000)

4. Family Planning Division:

This is headed by a Deputy Director from DoHFW. There are no single technical staffs for this crucial division. It is imperative that the division is strengthened by technical consultants as follows:

- Consultant (Sterilization & Temporary Methods)
- Consultant (QAC, Monitoring & Evaluation)

For Consultant qualifications prescribed are are MBBS, BAMS, BHMS, BUMS, BDS or any other graduate with a post-graduation in Public Health (MPH) or Management (MBA) or a postgraduate diploma in Health Management. 3-5 years of experience in the field of Health Programme Management is required. Experience in the field of Maternal or Child Health would be desirable. (Salary Rs.50,000)

5. ARSH:

The ARSH Division is led by a full time Deputy Director, who is from the Department of Health and Family Welfare. The Division deals with crucial programmes such as ARSH, School Health Programme and Iron plus Strategy. It is proposed to augment the capacity by inducting new staff as follows:

- Consultant– ARSH
- Consultant– School Health Programme
- Consultant– WIFS/Iron Plus

For Consultant qualifications prescribed are MBBS, BAMS, BHMS, BUMS, BDS or any other graduate with a post-graduation in Public Health (MPH) or Management (MBA) or a postgraduate diploma in Health Management. 3-5 years of experience in the field of Health Programme Management is required. Experience in the field of Maternal or Child Health would be desirable. (Salary Rs.50,000)

6. PIP Process:

At present the PIP process is led by the SPM who is assisted by a PIP Consultant. It is proposed to augment capacity of the PIP Process by including two more

- Consultant- District Planning-1
- Consultant-Project Planning and Implementation- 1
- Consultant- PIP Process-1 (Including monitoring of PIP Conditionality's Incentives/Disincentives, Mandatory Disclosures etc)

7. PCPNDT:

This is headed by a Deputy Director from DoHFW. There are no single technical staffs for this crucial division. It is imperative that the division is strengthened by technical consultants as follows:

- Consultant (implementation, M&E)
- Legal consultant.

For the Consultant (Implementation and M&E) the qualifications prescribed are MSc (Stat), MPH, MBA, MCA or post graduate diploma in Health Management. 3-5 years of experience in the field of Health Programme Management or Monitoring & Evaluation is required. (Salary Rs. 40,000 – Rs. 55,000)

For the Legal Consultant, the qualifications prescribed are a Bachelor's Degree in Law (LLB) with 8-10 years' experience in the field. Any experience in dealing with legal issues pertaining to PC-PNDT Act would be desirable.

8. Referral Transport:

This division is also being looked after by an officer of Deputy Director Rank from the Department of Health and Family Welfare. This division lacks the technical expertise, which is required to assess and monitor the functioning of the referral transport system in the State and monitor its functioning. It is therefore proposed to augment capacity as follows:

- Consultant (Implementation & Monitoring).

For the Consultant, qualifications prescribed are either MBBS, BAMS, BHMS, BUMS, BDS or any other graduate with a post-graduation in Public Health (MD-PSM or MPH) or Management (MBA) or a post graduate diploma in Health Management. 3-5 years of experience in the field of Health Programme Management is required. (Salary Rs. 40,000 – Rs. 55,000)

Summary of positions proposed(with salary) is as follows:

Sl. No.	Position proposed	Number	Salary proposed per month (in Rs)	Remarks	TA/DA per month (in Rs)
1	Maternal Health				
a.	Technical Adviser	1	70,000	Working	20,000
b.	Consultant (MDR, RTI/STI)	1	50,000	Recruitment under process	10,000
c.	Consultant (JSSK & JSY)	1	50,000		10,000
d.	Consultant (Training)	1	50,000		10,000
2	Child Health				
a.	Technical Advisor- Child Health	1	70,000	Working	20,000
b.	Consultant (Facility Based New Born Care)	1	50,000	Recruitment under process	10,000
c.	Consultant (SAM/NRC/MNRC)	1	50,000		10,000
d.	Consultant- (Training, including IMNCI, FIMNCI, NSSK etc.)	1	50,000		10,000
3.	Immunization Division:				
a	Consultant (Immunization, including AEFI,)	1	50,000	Recruitment under process	10,000
4.	Family Planning Division:				
a	Consultant (Sterilization & Temporary	1	50,000	Recruitment under process	10,000
b	Consultant (QAC, & Monitoring & Evaluation)	1	50,000	Recruitment under process	10,000
5.	ARSH:				
a	Consultant- ARSH	1	50,000	Recruitment under	10,000
b	Consultant- School Health Programme	1	50,000	Recruitment under	10,000
c	Consultant- WIFS	1	50,000	Recruitment under	10,000

6.	PIPProcess:				
a	ProjectPlanningandImplementationOverall PIP in charge	1	50,000	Working	10,000
b	Consultant- District Planning	1	50,000	Recruitment under	10,000
c	Consultant- Project Planning and Implementation	1	50,000	Recruitment under process	10,000
7.	PCPNDT				
	Consultant (implementation, M&E)	1	50,000	Recruitment under process	10,000
	Legalconsultant.	1	50,000	Working	10,000
8.	Referral Transport:				
a	Consultant	1	50,000	Recruitment under process	10,000

Budget estimation for 6months:

Sl.No	Particulars	TotalamountinRs. Budget	Remarks
1	The estimatedcosttohire Technicaladviser and consultant forVarious components of NRHM (Salary)	1,12,80,000	
2	Budget forTA/ DA	14,40,000	
3	Onetimelogisticexpenditurefor 19consultant (Laptop andother items)	13,30,000	
Total		1,40,50,000	

Totalbudgetrequirementfor6monthsisRs.1,40,50,000/- (RupeesOne crore forty lakhs and fifty thousand)

Funding proposed: Rs.3357.52

Details are as given below:

Programme Management						
SPMU						
Sl. No.	Designation	UNIT COST	NO OF UNITS	No. of months	TOTAL COST	FMR code
		(In Rs.)				
1	State Programme Manager	0	1	12	0.00	A.10.1.1
2	State Accounts Manager	0	1	12	0.00	A.10.1.2
3	State Finance Manager	0	1	12	0.00	A.10.1.3
4	State Data Manager	0	0	12	0.00	A.10.1.4
5	Advisor	70000	2	12	16.80	A.10.1.5
6	Consultants / Programme Officers (including for MH/CH/FP/ PNDT/ AH including WIFS SHP, MHS etc.)					A.10.1.5
a	Consultant (in position)	50000	1	12	6.00	A.10.1.5
b	Consultant (approved in 2013-14 but to be recruited)	50000	17	9	76.50	A.10.1.5
7	Programme Assistants					A.10.1.6
a	Programme Assistants (in position)	25000	5	12	15.00	A.10.1.6
b	Programme Assistants (approved in 2013-14 but to be recruited)	20000	15	9	27.00	A.10.1.6
8	Technical assistant	26500	1	12	3.18	A.10.1.6
9	Accountants	20000	2	12	4.80	A.10.1.7
10	Data Entry Operators	18000	70	12	151.20	A.10.1.8
11	Support Staff (Kindly Specify)					
a	Driver	18000	12	12	25.92	
b	Group-D	12000	30	12	43.20	
c	Cleaning staff	9000	6	12	6.48	A.10.1.9
d	Security guard	9000	3	12	3.24	
12	Salaries for Staff on Deputation (Please specify)	70000	1	12	8.40	A.10.1.10
13	HR for HMIS/MCTS					
a	State M & E Manager (existing)	30000	1	12	3.60	A.10.1.11.1
	State M & E Manager (new post)	30000	1	9	2.70	A.10.1.11.1

b	GIS Co-ordinator (existing)	40000	1	12	4.80	A.10.1.11.1
	GIS Co-ordinator (new post)	40000	1	6	2.40	A.10.1.11.1
c	HMIS/MCTS Co-ordinator (existing)	30000	2	12	7.20	A.10.1.11.1
	HMIS/MCTS Co-ordinator (new post)	30000	2	6	3.60	A.10.1.11.1
d	Field Co-ordinator – 2 for each Division	15000	8	12	14.40	A.10.1.11.1
14	Programme management cost at state level	1000000	1	12	120.00	A.10.11.1.3
Total					546.42	
15	Strengthening of District society/ District Programme Management Support Unit					
a	District Programme Manager	35000	33	12	138.60	A.10.2.1
b	District Accounts Manager	30000	33	12	118.80	A.10.2.2
c	District Data Manager	0	0	0	0.00	A.10.2.3
d	Consultants/ Programme Officers (Programme assistants)	16000	60	12	115.20	A.10.2.4
e	Accountants	16000	33	12	63.36	A.10.2.5
f	Data Entry Operators (RCH, NRHM & SH)	15000	90	12	162.00	A.10.2.6
g	Support Staff (Accounts Assistants for DH)	15000	35	12	63.00	A.10.2.7
h	HR for HMIS/MCTS (existing)	25000	14	12	42.00	A.10.2.8.1
i	HR for HMIS/MCTS (new post)	25000	16	9	36.00	A.10.2.8.1
j	Programme management cost at district level	100000	30	12	360.00	A.10.2.8.2
Total					1098.96	
16	Strengthening of Block PMU					
a	Block Programme Manager	20000	176	12	422.40	A.10.3.1
b	Block Accounts Manager	12500	176	12	264.00	A.10.3.2
c	Block Data Manager	0	0		0.00	A.10.3.3
d	Accountants	0	0		0.00	A.10.3.4
e	Data Entry Operators	12500	176	12	264.00	A.10.3.5
f	Support Staff (Kindly Specify)	0	0		0.00	A.10.3.6
g	Programme management cost at taluka level	10000	176	12	211.20	A.10.3.7.1
Total					1161.60	

17	Strengthening (Others)					
a	Workshops and Conferences	500000	1	1	5.00	A.10.4.1
b	Augmenting the FMG at state	737000	1	1	7.37	A.10.4.2
c	NRHM NFMIS	18853000	1	1	188.53	A.10.4.3
d	Strengthening FMG	2440000	1	1	24.40	A.10.4.4
e	Audit Fees	600000	1	1	6.00	A.10.4.5
f	Concurrent Audit system	2160000	1	1	21.60	A.10.4.6
g	Laptops and its accessories to consultants	70,000	19		13.30	A.10.4.5.
Total					266.20	
18	Mobility Support, Field Visits					
a	SPMU/State	30000	15	12	54.00	A.10.7.1
b	DPMU/District	30000	30	12	108.00	A.10.7.2
c	BPMU/Block	5000	176	12	105.60	A.10.7.3
d	Mentoring Visits – Involving Medical Colleges, NGOs & Other partners	9000	8	6	4.32	A.10.8
Total					271.92	
Grand Total					3344.10	

Programme Management Cost: (A.10.1)**Programme Management Cost at State level: continued activity.**

The State Health Society is the apex body at the State level overseeing the overall implementation of the NRHM programme across the state. The administrative unit and the finance unit together form the State Programme Management Unit (SPMU). This unit provides the Secretarial service for the SHS.

The State Programme Management Unit (SPMU) has been established to support and augment the Programme Management capability of NRHM. It strengthens the existing management structure at the State and forms an integral part of the NRHM programme.

The office expenses are essential for the day-to-day functioning of the programme. This includes expenses on telephone, electricity, water, stationery, CUG bills, internet, consumables, meeting expenses, hospitality, other miscellaneous expenses etc. An amount of Rs. 11.24 crores was allocated in 2012-13. In the current financial year of 2013-14, an amount of Rs. 1.36 crores has been provided, which is only sufficient for 6 months of salary of SPMU staff. It is noted with deep concern that the office maintenance costs have not been approved at all. The monthly breakup of Programme Management Cost at the state level is as follows:

SINo	Particulars	Average cost per month (Rs in lakhs)
01	Office Stationery	2.00
02	Electricity Cost	1.00
03	Water	0.50
04	Telephone (Landlines and Mobile)	2.00
05	Internet	1.00
06	Meeting Expenses	1.00
07	Hospitality	1.00
08	Miscellaneous	1.50
	Total	10.00

To meet any of the contingent expenditure @ Rs.10.00 lakhs/month towards the Programme Management Cost of SHS, in order to meet the contingent expenditures of the SHS.

Total amount requested: Rs.120.00 lakhs.

A.10.2. Supplementary proposal for Programme Management Cost at district level: Ongoing activity: Amount of Rs.12.00 lakhs per district per annum was approved in financial year 2013-14 to meet expenditure such as meeting cost, telephone bills, stationery, communication support, computer accessories, TA&DA etc. Hence for 30 districts it is proposed for Rs.360.00 lakhs

Amount requested: Rs.360.00 lakhs.

A.10.3. Supplementary proposal for Programme Management Cost at Taluk level: Ongoing activity: An amount of Rs.2.5 lakhs per taluk per annum was approved in financial year 2013-14 to meet expenditure such as meeting cost, telephone bills, stationery, communication support, computer accessories, TA&DA etc. Hence it is proposed an amount of Rs.211.20 lakhs has to be approved.

Amount requested: Rs. 211.20 lakhs

Mobility support:

For supportive supervision and effective monitoring 15 vehicles at state level, 30 vehicles at district level (1 vehicle per district) and Rs.5000.00 per month for 176 taluks towards TA/DA for BPMU staff for visiting below block level for checking of accounts, data verification and other supervisory activities is proposed.

Mobility Support, Field Visits						
a	SPMU/State	30000	15	12	54.00	A.10.7.1
b	DPMU/District	30000	30	12	108.00	A.10.7.2
c	BPMU/Block	5000	176	12	105.60	A.10.7.3
d	Mentoring Visits – Involving Medical Colleges, NGOs & Other partners	9000	8	6	4.32	A.10.8
Total					271.92	

Workshops and conferences: Karnataka Medical Council has made a mandate to earn credit points for all doctors for renewal of their KMC registration after every 5 years. Hence a budget provision of Rs.5.00 lakhs is made for reorientation training /workshops for all inservice doctors.(FMR A.10.4.1).

B.1 ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA)

Introduction:

Government of India has launched National 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 care delivery system. This caters to a population norm of 3,000 to 5,000, but is effectively serving a much larger population.

A new band of community functionaries named as Accredited Social Health Activist (ASHA) was 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 to access health services. The community will have 1 ASHA per 1000 population, when the population exceed more than 1000 another ASHA can be engaged.

Over the eight year period, the ASHA programme has emerged as the largest community volunteer health programme in the state with 33750 ASHAs trained. ASHA is considered as a critical contributor to enabling people's participation in health. ASHA acts as a healthcare facilitator, a service provider and a health activist involved in providing preventive, promotive and basic curative care services.

The role of ASHA is:

- Complementary to other health functionaries;
- Educating and mobilizing community particularly those belonging to marginalized groups, thus leading to behavioral change
- Create awareness on social determinants,
- Enhancing better utilization of health services;
- Participation in health campaigns and enabling people to claim health entitlements.

Objectives:

- To provide access to basic quality health care services particularly to women and children in order to reduce IMR & MMR by promoting the institutional deliveries
- Taking care of minor health problems at community level,
- To help in prevention and control of communicable and non-communicable diseases

ACITIVITIES:

B1.1.1 Selection and training of ASHA: (continued activity)

Every year there will be dropouts in ASHA numbers due to reasons which are mainly personal. Low incentive is also may be one of the reasonfor dropouts. State will therefore select new ASHAs in place of dropouts. During 2013-14 there were 5187 dropouts. We need to select the remaining ASHAs as it is very crucial for the health care activities that has to reach the vulnerable groups, more so in the hard to reach areas, wherever the posts of ANM is vacant, on priority in the villages without ASHAs, and in those villages with more than 1000 population having only one ASHA. Dropout rate is expected to be less hence forth with the releases of matching grants to ASHA from the state budget and non-monetary incentives like supply of mobile handsets from KHSDRP (World bank assisted project) and free CUG SIMS from NHM. Hence it is proposed to select 8151 (Dropout) ASHAs out of which (5809) 3975 ASHA are selected in 2013-14 but training is not conducted due to delay in printing of consolidated modules to train newly inducted ASHAs.

Criteria for selection of ASHA:

- ASHA primarily be a woman resident of the same villagepreferably selected among married/ widow/ divorced women/ (Separated and preferably in the age group of 25 to 45years.)
- She will be literate women with formal education upto10thclass. Preference will be given to SC/ST and backward communities. She will be selected through Grama Sabha from the Grama panchayat.

Achievement

29916 ASHAs are working at the end of March 2014 and around 15% ASHAs are dropout from the inception ASHA Programme.

Justification:

ASHA selection is one of the important interventions at the Gramasabha level of Gramapanchayatand the amount of Rs.550/- is utilized for the selection purpose. Hence this activity is continued.

Deliverables:

It is proposed to select 7033 ASHAs at the village level to fill the ASHA gap.

Induction training for ASHAs:(continued activity)

Capacity building of ASHA is a continuous process. Building ASHAs' knowledge base and her skill care is critical in enhancing her effectiveness to achieve the

desired healthcare outcomes. The duration of training is good enough to build her skills. All newly selected ASHAs will undergo eight days residential induction training in 1st to 5th training modules.

Achievement:

During 2013-14 it was planned to train 5809 ASHAs. But the training programme could not be taken up because of Kannada translation of the training modules was not ready. Hence it is now planned to carry forward the activity for 2014-15.

Justification:

Selection and training of ASHAs is a major intervention at the village level in order to deliver the quality health care services to the vulnerable groups for woman and children. Hence it is proposed to continue this activity.

Deliverables: Trained ASHAs will be able to take care of essential tasks such as:

- Maternal Care (Counselling of ANC, Complete ANC care, Making the birth plan for safe delivery, PNC visits and Family Planning)
- Newborn Care (Counselling regarding breast feeding and keeping the baby warm, Identifying LBW babies)
- Child Care (Home care for Diarrhoea, ARI, fever)
- Nutrition (Counselling for exclusive breast feeding, on complementary feeding and referral of malnourished children)
- DCPs : Infections (Identifying the persons whose symptoms are suggestive of Malaria, Leprosy and TB)
- Social Mobilization (VHSNC meetings, VHNDs, preparing village health plans and other related activities)

ASHA Induction training cost break up						
Sl.N o.	Activity	Unit cost	No. of units	No. of days	Total amount	in lakhs
	Training in I-V module (11008 ASHAs to be Trained in 375 Batches)					
1	Wage Loss Compensation	150	11008	8	13209600	132.10
2	TA,/DA,	200	11008	8	17612800	176.13
3	Venue,/accommodation,	200	11008	2	4403200	44.03
4	Resource person's honorarium	600	375*2=750	8	3600000	36.00
5	Resource person's Travel	200	375*2=750	2	300000	3.00
6	Training material etc				18750000	187.50
Grand Total					57875600	578.76

Funding proposed

Rs. In Lakhs

Sl. No.	Activity	No. of units	Unit cost	Amount proposed	FMR code
1	ASHA selection and training	7033	550	38.68	B.1.1.1.1
2	New ASHA training	11008	5258	578.76	B1.1.1.1
Total				617.44	

HOME BASED NEWBORN CARE (HBNC)

It is a continued activity.

HBNC training program is mainly aimed to build the capacity of ASHAs for providing the essential skills for birth preparedness, routine new born care, supporting breastfeeding, common issues in the newborns apart from the illnesses, identifying the common danger signs in newborns and mothers, early referral, counseling the mother and family on birth spacing, immunization, etc. there by reducing the IMR and MMR.

- Training sites** - DTCs/HFWTCs and Identified Taluka hospitals
- Trainers** - ASHA mentors who have undergone the TOTs
- Trainees** - ASHA's who have completed the basic ASHA training
- Batch size** - 30 per Batch
- Duration** - 20 days

B1.1.1.2 HBNC training is given in Two patterns

- HBNC Training of ASHA 6 & 7 Module of GOI Pattern
- HBNC Training of Gadchiroli pattern

3) HBNC Training of ASHA 6 & 7 Module of GOI Pattern

The care of the ANC, new born and postnatal mother is very essential. In order to support ANMs, ASHAs are trained in this program for 20 days (2 workshops of 10 days duration each) as per GOI guidelines in cascading model. In this, 6 post natal visits by the ASHAs are mandatory.

CONTENTS OF ASHA MODULE TRAINING (6 & 7)

Round 1 & 2 - duration: 10 days

- Introduction to ASHA 6 & 7 module:
Role of ASHA, essential skills about management of new born, Home visit, VHND
- Maternal health:

- Confirmation of pregnancy
- Planning for safe delivery
- Anaemia
- Complication during pregnancy & delivery
- Care during delivery & post delivery
- Planning of home visits

Round 3 & 4- duration: 10 days

- Child health & nutrition
- Women's reproductive health
- Newborn health
- Introduction to infectious diseases
- Filling of forms

HBNC training of Gadchiroli pattern (Model)

Home based Newborn Care of Gadchiroli pattern is followed in 7 'C' category & Chamara Nagar districts. The HBNC training of Gadchiroli pattern does not include the Care of child from 2 months to 5 years, Reproductive health (family welfare methods), Control of communicable diseases – especially Malaria, Tuberculosis & HIV/AIDS. These topics are included in round 5. We have not adopted the practicing of Ambu bag and administration of injection Gentamycin & Vitamin-K of Gadchiroli pattern.

Contents of round 1 & 2: Duration 8 days

- Introduction to HBNC programme
- Local practices about pregnancy, delivery and new born care
- Role of ASHA in HBNC programme
- IEC/BCC activities – using flip charts
- Calculating EDD on the basis of LMP
- Home visits to ANC & PNC and filling of forms
- Observation during delivery & new born care
- Time recording by using digital watch
- Weighing of new born

Contents of round 3 & 4: Duration 6 days

- Identification of high risk new born & its management
- Breast feeding
- Filling of home visiting forms
- New born resuscitation using mucus sucker
- IEC/BCC activities using flip charts
- How & when to refer the sick child
- Keeping the baby warm
- Planning of home visits etc.,

Contents of round 5: Duration 6 days

- Care of child from 2 months to 5 years
- Reproductive health (family welfare methods)
- Control of communicable diseases – especially Malaria, Tuberculosis & HIV/AIDS.

HBNC Training		
Rounds	ASHA 6 & 7 GOI Pattern	Gadchiroli Pattern
Round 1 & 2	10 days	8 Days
Round 3 & 4	10 days	6 Days
Round 5	-	6 Days

Total no. of ASHA's functioning in the state are 30175

4) **No. of ASHA's Trained in Round 1 & 2 upto Feb 2014** – 29751

Balance – 424 to be trained

Newly selected ASHA's – $3950 + 1530(\text{urban}) = 5880$

Target for the F Y 2014-15 – $3950 + 424 + 1530 = 5904$ (in 197 Batches)

5) **No. of ASHA's Trained in Round 3 & 4 upto Feb 2014** – 27306

Balance – 2869 to be trained

Newly selected ASHA's – $3950 + 1530(\text{urban}) = 5880$

Target for the F Y 2014-15 – $3950 + 2200 + 1530 = 7680$ (in 256 Batches)

6) **No. of ASHA's Trained in Round 5 upto Feb 2014** – 7146 (Out of 8098 of C category Dist.)

Balance – 952 to be trained

Newly selected ASHA's – 570

Target for the F Y 2014-15 – $570 + 700 = 1270$ (in 43 Batches)

Total No. of ASHA's to be trained:

Round 1&2: 5904 (in 197 Batches)

Round 3&4: 7680 (in 256 Batches)

Round 5 : 1270 (in 43 Batches)

14854 ASHA's to be trained in 496 Batches.

Justification:

ASHAs who are already in the field trained in basic modules are to be equipped with the basic child health management for which HBNC training is very essential.

Deliverables:

Taking care of the new born and the child in the development and in sickness.

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1.	ASHA Training Module 6 & 7	496	182650	905.94 Lakhs	B1.1.1.2	

B1.1.2.4 ASHA HBNC New Kits**It is a continued activity.**

The ASHA HBNC kits consists of essential equipment's required to assist the ASHA in taking care of the new born / child in the field.

HBNC Kit consists of:

- Spring weighing balance
- Digital thermometer
- Digital wrist watch &
- Baby warmer bag

Achievements:

Total No. of ASHA's : 30175

Total No. of HBNC kits given to ASHA's : 29903

Total No. of HBNC kits needed for the F Y 2014-15 : 3000 +1600 (urban) = 4600 (For newly recruited ASHAs)

Cost per unit : 1100

Justification:

The HBNC kits given to ASHA (29903) are helping them to manage the HBNC activity in the field. Hence it is very essential to provide the kits to the remaining ASHAs who are to be trained

Funding proposed

Sl. No.	Activity	No of Units	Cost Per Unit	Total	FMR Code	Remarks
1	ASHA HBNC New Kits	4600	1100	50.60 Lakhs	B1.1.2.3.1	

Supplementary and refresher trainings:

It is a continued activity.

Annually at least 15 days of training will be planned in which new topic and skill will be added, which are specific to local needs. Skills in certain areas such as disability screening, mental health counseling, etc. that the state would prioritize can be taught to selected ASHAs rather than all ASHAs.

Situation analysis of ASHAs

Year	Selected and trained	Working	Drop out	% of drop out	Remarks
2007-08	11205	10879	326	3	High focus on north Karnataka
2008-09	16635	14259	2376	14.2	
2009-10	10734	8612	2122	19.7	
2010-11					
33750 till June 2010-11					
2011-12	1110	33750			
2012-13	950	30175		14	
2013-14	3975	29916	5809	15%	Training to be completed

ASHAs have been trained as shown in the above table. At the end of March 2014 there were 29916 ASHAs working in the state, there has been drop out in few districts. During the FY 2013-14, ROP approval was received to select 5809 ASHAs. At present 3975 ASHAs were selected in the state. The backlog of 1860 ASHAs will be taken up for the FY 2014-15, in those villages where there are no ASHAs, and the dropout rate is too high.

It is proposed to train the ASHAs through satellite training at one go in all the talukas of the districts at the cost of Rs.435/- per each individual.

Justification:

ASHAs once trained are catering services in the selected villages. They need refresher training to update their skills and knowledge in order to deliver the quality health services and also they will be updated with the new technical skills. Hence the activity is continued and proposed.

Deliverables:

It is planned to train 29916 ASHAs in all the talukas through satellite training. Their knowledge and skills will be updated and recent technical guidelines will be delivered.

Funding proposed**Rs. In Lakhs**

Sl. No.	Activity	No. of units	Unit cost	Amount proposed	FMR code	Remarks
1	Supplementary and refresher trainings	29916	450	134.62	B1.1.1.3	New activity
Total				134.62		

Selection of Facilitators & Training:

It is a continued activity.

In order to strengthen the working atmosphere of ASHAs, for every 20 ASHAs one facilitator (best performing ASHA) will be identified as ASHA facilitator. Every PHC will thus have 1-2 facilitators, she will be required to work for 20 days in the field and to compensate her wage loss, she may be paid Rs.200/- per day and Rs.50 for TA(including for PHC Review meeting) .The Taluka Health officer, Mentor and ANM will choose from the existing ASHAs the ones who have better community acceptance and has been successful in her role as ASHA as the facilitator.

In the supplementary PIP 2013-14, 1800 facilitators were sanctioned for the state; the districts are in the process of completion of selection and training the facilitators. The facilitator will be paid an honorarium of Rs.5000/- for 20 working days in the field/month

Justification:

In order to monitor the ASHA performance and guide them it is proposed to have one facilitator for 20 ASHAs. Hence it is proposed to continue this activity.

Deliverables:

It is a supportive system to enhance the performance of ASHAs.

Funding proposed

Sl. No.	Activity	No. of units	Unit cost	Amount proposed	FMR code	Remarks
1	Supervision costs by ASHA facilitators(12 months)	2200	5000(5000 *12)	1320.00	B1.1.1.4.1	(Rs.2000 per facilitator per month)
Total				1320.00		

Drugs for ASHA:-

ASHAs across the state have been trained to treat minor ailments like fever, cold, abdominal pain, vomiting, and diarrhoea. In 2008-10 the state had provided drugs to them after the completion of their induction training. In 2011, the districts were asked to procure from the VHSNC untied funds. 2012-13 PIP there was no proposal from the state as the PHC medical officers had to replenish the drugs wherever the ASHA needed it.

ASHA Drug Kits	
Number of ASHA engaged (Trained in Module-1-V)	29916
Number of ASHA with Drug Kits	Not issued in the FY 2013-14 awaited supplies from KSDLWS
Number of ASHA with HBNC Kits	: 29903
Number of New Drug Kits required	11008
Number of Drug Kits to be replenished	29916
Number of New HBNC Kits required	4600
Number of HBNC Kits to be replenished	4600

Sl. No	Name of drugs in drug Kit
1	Albendazole suspension bottle strength
2	Paracetamol Syrup
3	Oral rehydration salts
4	Povidone Iodine
5	Paracetamol Tab
6	Cotrimoxazole suspensions
7	Cotrimoxazole DS Tab
8	Gentamycin eye drop
9	Absorbent cotton wool

Funding proposed

Sl. No.	Activity	No. of units	Unit cost	Amount proposed	FMR code	Remarks
1	Procurement of ASHA Drug Kit New Kits	11000	1300	143.00	B1.1.2.1	
2	ASHA Drug Kit Replenishment	29916	300	89.75	B1.1.2.2	
Total				232.75		

List of performance incentives under RCH Flexi pool Components (A) with rates;

ACTIVITY PROPOSED: Incentives to ASHA under JSY beneficiary scheme.1case (apart from Scheduledtribe's beneficiaries (A1.4.3)

It is a continued activity

ACHEIVEMENT: ASHA incentive is paid to the JSY beneficiaries @ of Rs.600/- .During 2013-14 JSY incentives is paid Rs.**2345.41**Lakhs

JUSTIFICATION:

ASHA will take steps to create awareness and provide information to the community regarding services available at health facilities and encourage InstitutionalDelivery. The communities will have a trust in ASHA and utilize the service provided by the public health facilities. This will also leads in reduction in MMR and IMR rates. Hence this activity is proposed.

DELIVERABLES:

- Enhanced registration of pregnant women
- Reduction in Home deliveries
- Safe Delivery
- Arranging for the Transport and if possible escorting the pregnant women
- JSY has also helped in increasing access to better Antenatal, Post natal care and Contraception services

FUNDING PROPOSED:

SI no.	Programs	No. of Units	Unit cost	Amount proposed	Line Item Number	Remarks
(1)	(2)	(3)				(4)
1.	A)Registration of pregnant woman within 12 weeks providing 100 I.F.A. Tablets and ANC checkup for 3 times and 2 TT immunization Helping pregnant woman to deliver in Hospital(PHC and superior hospitals) only for BPL,SC and ST beneficiaries	550000	Rs.600	3300.00	A.1.3.4	Rs 300 for Antenatal component and Rs 300 for facilitating institutional delivery)

List of performance incentives under NRHM Additional ties Components (B) with rates;

ACTIVITY PROPOSED:PerformanceIncentives to ASHA under NRHM Additional ties. (PACKAGE) (B1.1.3)

It is a continued activity

SI no.	Programs	New or Continued
(1)	(2)	(3)
1.	ASHA shall visit postnatal period minimum six times(1day,3day,5 th day,7 th day,15 th day and 21 st day) within 30days after the delivery (After complication of	Continued

	HBNC Training ASHAeligible for Rs 250 Non trainedASHAs eligible for Rs 100)	
2.	O.P.V 0 dose, Hepatitis B,BCG (Birth dose)DPT 3dose,polio 3 dose, Hepatitis B 3 dose After 9 th month Measles and Vitamin A Administration. Pay 100 per beneficiary.	Continued
3	By reporting the side effect of immunization. Programme(AEFI)helping them to get treatment	Continued
4	Reporting the maternal death within 24 hours to RCH officers/Medical officer of PHC	Continued
5	If woman are motivated for family planning sterilization. ASHA must considered motivator (If she is the Motivator)	Continued
6	If men are motivated undergo NSV family planning. ASHA must considered motivator (If she is the Motivator)	Continued
7	Under family welfare programme motivation for copper-T insertion after the first delivery and assisting them to insert copper-T in sub centers / Hospitals.	Continued
8	Escorting the client to the health facilities for facilitating the Post-partum IUCD insertion	NEW
9	Ensuring monthly follow up of low birth weight babies and new born discharged after treatment from specialized new born care units.	
10	Line listing of household done at beginning of the years updated after six months, maintaining village health register and supporting universal registrations of births and deaths, preparing of due children to be immunized on monthly basis, preparing list of ANC beneficiary to be updated on monthly basis and preparing of list of eligible couples updated on monthly basis.	NEW
11	If the medicine is given after blood smear taken in fever cases Rs 5 / per slide for maximum 10 cases Rs 50 can be paid	Continued
12	Identify in the person who is having white patches on the skin and confirmed as leprosy through PHC Doctors, for each case.	Continued
13	If leprosy cured completely and confirmed through PHC doctor MB& PB for each case.	Continued
14	Organise V.H.N.D. at village lever Regularly V.H.N.D. programme will be organized, participating in such programme, for each programme amount will be paid (Minimum 20 beneficiary signature is compulsory)	Continued
15	About Maintaining the document of the annual expenditure: IF to Maintenance of daily expenses ,account of annual expenditure under the programme of the untied fund for village sanitation and beneficiary amount incentive amount will be given ASHA worker	Continued
16	About House to house survey: If ASHA worker conduct house to house survey(CNA) in village and maintain the document the amount will be paid	Continued

17	About Attending the village sanitation meeting About attending the village and sanitation meetings and made them to attend the meetings and compulsory discussions should take place in meeting for that activity incentive amount will be (Proceedings report should be submit)	Continued
18	About attending the monthly meeting at PHC level: Incentive for To attend the monthly meeting and maintain the report and to understand all programme, for all this activity travel expends and other expenses can given.	Continued
19	Monthly travel allowance	Continued
20	About Abortion (M.T.P) : If ASHA encourages for M.T.P.in hospital as medical process incentive will be given.	Continued
21	Sncu - accompanying the child diagnosed with the ailment to higher referral center ensuring treatment after discharge ensure baby healthy	NEW
22	SAM accompanying the child diagnosed with the ailment to higher referral center along with parents and ensuring treatment	Continued
23	Participation in the Vitamin A supplementation programme and supporting the JHA in identification of children's, provision of vitamin A supplement and document the same	Continued
24	Reporting of Out breaks in village like Chicanguniya,Dengu,Gastroentretiteis,etc	Continued
25	IFA Tables :- identifying ANCs and examine Hb % and below 7% ANCs for providing 100 IFA tables for three months and after completion of treatment HB% shall rise 11% if it's not raised continue treatment further one months for one case paying.	Continued
26	HIV: bringing ANCs for HIV test propose if ANCs conform positive providing for high care up to delivery	Continued
27	Postnatal care for HIV Mothers: 1. Follow up of HIV Positive postnatal mothers and HIV exposed Children for 18 Months. 2. Taking HIV positive mothers for ART Centre for examination and management.	
28	Child Care in HIV Positive Cases: After delivery ASHA should visit PNCs and encourage breast feeding and arrange to provide examination at ART center.	

ACHEIVEMENT: Under this line item performance incentive paid to the ASHAs during 2013-14 Rs. 1882.141

JUSTIFICATION:

- The NRHM Institutionalized access to ANM services by popularizing the concept of fixed monthly village and nutrition day in every village.
 - By carrying out a complete pregnancy check up the ANM is able to detect problem and decide on referring the women to a doctor Example severe anemia, pre eclampsia, multiple pregnancies repeated abortions etc.
 - The role of social determinants in health outcomes needs to be recognized and addressed even as we acknowledge the gains in core health outcomes from NRHM investments.
 - The role of infant, Child and adult nutrition, literacy, particularly amongst Girls access to clean drinking water and sanitation facilities and gender equity are key determinants of good health which have a direct correlation to maternal. Newborn and infant health.
 - Low access to water and sanitation contribute to a high degrees burden in rural and urban areas. The data from census 2011 shows that nearly 50% of India's Population has no access to Toilets and per force resort to open defecation.
 - Less than half of the population has access to drinking water within the premises of their homes; acceleration of gains in health outcomes will now require greater attention to social determinants through convergent action by multiple stake holders and cannot be limited health system improvement alone.
 - The developmental of capacity in facilities to provide care for sick child , institutional care for children with severe malnutrition, complimenting these strategies was a major thrust at introducing home based care for the newborn and sick child through ASHAs
 - Awareness on sanitation personal hygiene and accessibility of health services has improved better utilization of RCH services.
 - 50 % of the pregnant women are anemic among pregnant women's, early detection of anemia in pregnant women to prevent complication during pregnancy and delivery.
- In order to deliver the above services it is proposed to continue the activity.

DELIVERABLES:

- Scheduled visits in HBNC, the purpose of HBNC is to enable the states to develop and operationalise the strategies to ensure that all newborns are provided with home based care, through a series of visits by ASHAs and ensuring that has the skills and support to do so.
- ASHA will undertake home visits to ensure that the newborn is being kept warm and breast fed exclusively. Encourage the mother to breast feed discourage harmful practices such as bottle feeds, early baths, giving other substances by mouths. Frequent home visits will help in identifying the early signs of infection, other illnesses in the newborn.
- ASHA will list all the pregnant women's which are tent to get left out (SC ST) communities, women living in hamlets
- Early registration of Pregnancy will be done by ASHAs within twelve weeks of pregnancy.
- ASHAs will ensure full ANC checkup (4 ANC visits) and ensure that the THAYI Card is filled.

- ASHAs will counsel the pregnant women and family on importance of balanced and nutrition diet, danger signs during pregnancy, supplementarycereals from AGANAWADI centers, Extra care for pregnant Adolescent girls and safe Institutional delivery and transport options available in the area.
- ASHAs will counsel mother and new born for appropriate care.
- The HBNC ensures that mother and newborn have access to services in order to ensure positive health outcomes; they will carry at least 6 visits for institutional deliveries and 7 visits for home deliveries.
- ASHAs will counsel the mother on Nutritious diet, adequate rest, exclusive breast feeding, postnatal check up, timely birth registration and possible complication for this period like anemia, fever, abnormal behavior of the delivery foul smelling discharge.
- Improved in reporting of Infant death and Maternal deaths
- Timely referral to the high risk pregnant women and sick neonates
- Increased utilization of untied funds in VHNC.
- Improve in village health sanitation.
- Help in prevention and control of communicable and non communicable diseases.

FUNDING PROPOSED:

SI no.	Programs	No. of Units	Unit Cost	Amount Proposed	FMR code	Remarks
1	Incentive for Home Based Newborn Care programme Undertaking six (in case of institutional deliveries)and seven (for home deliveries) home visits for the care of the new born and postpartum mother.	255400	Rs.250	638.5	B1.1.3.2.1	
2	Incentive for follow up of LBW babies: Ensuring monthly follow up of low birth weight babies and newborns discharged after treatment from specialized New Born Care Units.	29241	Rs 500	146.21	B1.1.3.2.2	Rs 50/case follow up upto 10 months(50*10=500)
3	Incentive to ASHA for follow up of SNCU discharge babies	29241	Rs 500	146.21	B1.1.3.2.3	RS 50/month follow up upto 10 months(50*10=500)
4	Incentive for referral and Admission of SAM cases to NRC	4000	RS.300	12.00	B1.1.3.2.4	
5	Incentive for follow up visits after child is discharge from NRCs or community based SAM management and till MUAC is equal to or more than 125mm.	4000	RS.150	6.00	B1.1.3.2.5	No of follow up will be 2 by each ASHA. After 3rd visit Rs 150 will be given to ASHA

6	RBSK :Identifying and referral of Birth defects and developmental delays and disability under RBSK	273999	Rs 100	274.00	B1.1.3.2.6	
7	Informer of Infant Death	12800	RS.100	12.8	B1.1.3.2.7	
8	ASHA PPIUCD incentive for accompanying the client for PPIUCD insertion	30000	RS.150	45.00	B1.1.3.3.1	
9	ASHA incentive under ESB scheme for promoting spacing of births	6000	RS.250	15.00	B1.1.3.3.2	
11	(M.T.P) : If ASHA encourages for M.T.P.in hospital as medical process incentive will be given.	40000	Rs 100	40.00	B1.1.3.3.4	
12	If woman are motivated for family planning sterilization. ASHA must considered motivator (If she is the Motivator)	25000	Rs 150	375.00	Under Family Planning funds (A.3)	
13	If men are motivated undergo NSV family planning. ASHA must considered motivator (If she is the Motivator)	4000	Rs 200	8.00	Under Family Planning funds (A.3)	

14	Under ASHA Routine ActivitiesOrganizing V.H.N.D. programme at village level regularly V.H.N.D. for each programme amount will be paid (Minimum 20 beneficiary signature is compulsory)	480000	RS.200	960.00	B1.1.3.6.4	
15	Attending the village sanitation meeting About attending the village and sanitation meetings and made them to attend the meetings and compulsory discussions should take place in meeting for that activity incentive amount will be (Proceedings report should be submit)	480000	RS.150	720.00	B1.1.3.6.5	
16	About attending the monthly meeting at PHC level:Incentive to attend the monthly meeting and maintain the report and to understand all programme, for all this activity travel expenses can be given.	480000	RS.150	720.00	B1.1.3.6.1	
	Line listing of household done at the beginning of the year and updated after six months.	12	Rs 100	0.012		
	Maintaining Village health register and supporti ng universal registration of births and deaths.	12	Rs 100	0.012		
	Preparing of Due list of children to be immunized updated on monthly basis	12	Rs 100	0.012		

	Preparing of list of ANC beneficiaries to be updated on monthly basis.	12	Rs 100	0.012		
	Preparation of list of eligible couples updated on monthly basis	12	Rs 100	0.012		
	HIV: bringing ANCs for HIV test purpose if ANCs conform positive and follow up upto delivery	1800	1000	18.00	B.1.1.3.1.1	
17	Reporting the maternal death within 24 hours to RCH officers/Medical officer of PHC	144	RS 500	0.72	B1.1.3.6.7	
18	By reporting the side effect of immunization. Programme(AEFI)helping them to get treatment	1023	Rs.100	1.00	B1.1.3.6.8	
19	About House to house survey: If ASHA worker conduct house to house survey(CNA) in village and maintain the document the amount will be paid	29916	Rs.100	29.9	B1.1.3.6.9	
20	Participation in the Vitamin A supplementation programme and supporting the JHA in identification of childrens,provision of vitamim A supplement and document the same		Rs.100		B1.1.3.6.10	

ASHA incentives for Full immunization (C1.1)

Continued activity

ACHEIVEMENT: Under this line item during 2013-14 Rs. 277.00 Lakhs has been paid as ASHA incentives for Full immunization.

JUSTIFICATION:

ASHA will take steps to create awareness and provide information to the community regarding Immunization Services available at Health facilities and mobilize the children from the community to the outreach sessions.

DELIVERABLES:

- Enhancement of complete immunization.
- Reduction in vaccine preventable diseases.

FUNDING PROPOSED:

SI no.	Programs	No. of Units	Unit cost	Amount proposed	Line Item Number	Remarks
1	ASHA Incentives for Full Immunisation (O.P.V 0 dose, Hepatitis B,BCG (Birth dose)DPT 3dose, polio 3 dose, Hepatitis B 3 dose After 9th month Measles and Vitamin A Administration. Pay 100 per beneficiary.)	1034965	Rs.100	1035.00	C5	
2	Mobilization of children through ASHA or other mobilizers	279559	Rs.100	280.00	C.1.h	279559 Immunisation sessions

ASHA incentives for RNTCP programme.

It is a continued activity

ACHEIVEMENT:Under this line item during 2013-14 Rs. ---- Lakhs has been paid as ASHA incentives for Full immunization

JUSTIFICATION:

- ASHA will take steps to create awareness and provide information to the community regarding Tuberculosis.

DELIVERABLES:

- ASHA s does counseling for the TB cases and motivates them for complete treatment.
- ASHA s refers suspected TB cases to the nearest health facilities for sputum examination
- ASHAs acts as a DOT providers and make sure that medicine are taken by the patients for 6-9 months, counsel patients on taking extra nutrition and build awareness in the community by preventing the spread of TB by infected person.

FUNDING PROPOSED:

SI no.	Programs	No. of Units	Unit cost	Amount proposed	Line Item Number	Remarks
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1	Under the national TB control programme participating – Providing DOTS (to give total recovery treatment) for one such case (ASHA workers are Identified DOTS providers).		Rs 2500/-		RNTCP 3	Rs 1000/-for 42 contacts for Cat I TB patients(newcases) over 6—7 months of treatment. Rs 1500/- for 57 contacts for Cat II TB patients over 8—9 months of treatment including 24—36 injections in intensive phase
2	Incentives to community DOT providers providing treatment and support to drugs resistant TB Patients		Rs 5000/-		RNTCP 3	Rs 5000 for completed course of treatment (Rs 2000/- at the end of IP and Rs 3000/- at the end of CP)

ASHA incentives for NVBDCP Programme.

It is a continued activity

ACHEIVEMENT: Under this line item during 2013-14 Rs. ---- Lakhs has been paid as ASHA incentives under NVBDCP

JUSTIFICATION:

- In the vector borne disease control programmeASHAs are involved for early identification of cases and supporting treatment of malaria cases on day to day basis. They are expected to screen for suspected fever cases and support malaria treatment. Hence it is proposed to continue this activity.

DELIVERABLES:

- During house visits and in the VHND meetings ASHAs will inform the community about malaria, how to prevent it and what to do for fever. They will encourage and help the VHSNC and women's groups or other community organizations to take appropriate corrective action to prevent malaria in that area.
- They also actively participate in source reduction.
- ASHAswillcollectblood samples and prepare the slides from the suspected fever cases and send to Lab for further detection of MP.

FUNDING PROPOSED:

SI no.	Programs	No. of Units	Unit cost	Amount proposed	Line Item Number
(1)	(2)	(3)	(4)	(5)	(6)
1	Preparing blood slides	1,50,000	Rs.15/-	22.5	NVBDCP
2	Providing complete RDT Positive PF cases and providing complete radical treatment to positive PF and PV cases detected by blood slide, as per drug genuine.		Rs 75/-		NVBDCP
3	For referring JE cases to the nearest PHCs/DH/Medical College and ensuring complete treatment (ASHA /Volunteers)		Rs.300/-		NVBDCP
4	Lymphatic Filariasis- for one time Line listing of Lymphoedema and Hydrocele cases in al villages of endemic and non endemic district		Rs 200/-		NVBDCP

ASHA incentives for NLEP Programme**It is a continued activity****JUSTIFICATION:**

- At community level,ASHAs are involved in the eradication of leprosy program to mobilize all suspected individuals for medical examination and further management, which includes completion of long course of treatment. Acting as a point person particularly for referring suspected complaints to health facilities, following up for treatment and encouraging self care for prevention of disability in leprosy patients

DELIVERABLES:

- ASHAs identify the person who is having suspected patches on the skin and refer to the PHCs for the confirmation of leprosy.
- ASHAs follow up the leprosy patients till the patient complete the treatment.

FUNDING PROPOSED:

SI no.	Programs	No. of Units	Unit cost	Amount proposed	Line Item Number	Remarks
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1	Referral and ensure compliance of complete treatment in Pauci-Bacillary cases of Leprosy	375	Rs 300/-	1.13	NLEP	Rs 100 on registration for treatment of referred case and 200 for completion of treatment for PB case
2	Referral and ensure compliance of complete treatment in Multi-Bacillary cases of Leprosy	417	Rs 500/-	2.1	NLEP	Rs 100 on registration for treatment of referred case and 400 for completion of treatment for PB case

ASHA incentives for IDSP:It is a continued activity

JUSTIFICATION:At community level,ASHAs are involved in the reporting of Out breaks in village like Chickenguniya,Dengu,Gastroentretiteis,etc and to mobilize all suspected individuals for medical examination and further management, Acting as a point person particularly for referring suspected patients to health facilities, following up for treatment and encouraging self care for prevention by creating awareness among the community.

DELIVERABLES:

- ASHAs identify the person who is having suspected cases outbreak of communicable diseases and refer to the PHCs for the confirmation and treatment.
- ASHAs follow up the patients till the patient gets complete cure.

SI no.	Programs	No. of Units	Unit cost	Amount proposed	Line Item Number	Remarks
1	Reporting of Out breaks in village like Chikunguniya, Dengu, Gastroentretiteis, etc		Rs.10 0/-		IDSP	

Human Resource under ASHA:

ASHA Resource center in the state office is at present having one State Programme officer for ASHA, and a Data Entry operator. There is an urgent need to support and strengthen the existing structure to document, analyze and monitor ongoing activities in the districts more effectively. The ARC is proposed to be therefore strengthened by appointing two Programme managers, one to monitor ongoing trainings, review and do supportive supervision for at least ten days in a month and the other to monitor the VHSNC meetings, utilization of untied funds and other community processes. It is also proposed to appoint an accounts assistant for the ARC. Details are as follows:

Programme Manager ASHA:- Candidate to be selected must be a post graduate diploma/degree in Public health/community medicine/MSW, who has three to five years experience in training /capacity building , planning and monitoring and possess good communication skills (verbal and written) and is computer savvy. Salary proposed is Rs.2.75 lakhs, @ Rs.45000/month

Accounts Assistant:- Candidate with Bachelor's degree in Commerce, with computer proficiency in MS word, Excel, spread sheets for financial analysis; three years working experience of Tally ARN 9. He/She will be responsible for placement of funds, receipt of utilization certificates from the districts, and other expenditures related to the programme.

Salary proposed is Rs.15000/month, budget required is 0.9 lakhs.

III) Proposal For ASHA support structure: - Existing support structure at the district and taluk level consists of at the district a DPMO, assisted by DPM, and District Mentor who is a staff nurse by qualification. In the Taluk/Block there is a BPM and Block Mentor. Each mentor in the block has about 100-150 ASHAs in small districts and 250-300 ASHAs in large districts where there are 7-11 blocks.

Mentors are deputed for 10 days to the District training centers whenever there are HBNC trainings in the district. She has to make field visits and prepare reports and bills to pay the ASHAs in the taluk health office. There is paucity of time for the mentor to visit the field regularly for supportive supervision.

ASHA-Annexure-V

Human Resource	Required as per norms	Approved 2013-14			Proposed 2014-15			Line Item Number
		No. In position	Monthly Remuneration	Total Amount Approved	No.	Monthly Remuneration /expenditure	Total Amount	
State Level								B1.1.5.1
	State Programme officer	1	Regular officer (paid by state govt.)	NA	0	0	0	
	ASHA programme manager	0	0.45	2.70	1	0.45	5.40	
	Accounts Assistant	1	0.15	0.90	1	0.15	0.90	
District Level								B1.1.5.2
ASHA Mentors	District Community Mobilizer salary	30	0.11	39.60	30	0.11	39.00	
	Office contingencies				30	0.01	2.70	
Block level								B1.1.5.3
ASHA Mentors	Block community mobilizer salary	176	0.10	211.20	176	0.10	211.20	
	Contingency for stationary & meeting expenses				176	0.01	15.84	
Total		176.00	0.10	211.20	176.00	0.13	292.16	

UNIFORM AND OTHER MONETARY INCENTIVE FOR ASHA.It is a continued activity....

ASHA is a primarily an Honorary volunteer but is compensated for her time in specific situation like attending training monthly review and other meetings. Along with performance incentive she should be given non-monetary incentives (exposure visits, annual conventions), group recognition/awards and CUG sim.Further. This has been done in other states as well. Hence it is proposed to supply CUG SIMS to all ASHAs in Karnataka.

ACHEIVEMENT: Every year they are provided one pair of sarees every year from VHSNC fund.

JUSTIFICATION:Social recognition takes place at group level which projects the ASHA as a person holding immense responsibility and an important committee resource to overcome barriers to accessing health care services. Providing a pair of sarees every year its self would be an incentive. ASHAs need to communicate to their mentors /ANMs /Medical Officers to inform vital events like infant /maternal death/outbreak of dengue, GE etc. It would therefore be helpful if we were to provide free CUG SIMSand recurring costs for the sims.

DELIVERABLES: ASHA will be motivated to work....

SI no.	Programs	No. of Units	Unit cost	Amount proposed	Line Item Number	Remarks
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1	CUG SIM cost of other non-monitory incentives to ASHA	35356 (35150 ASHAs+206 ASHA Mentors)	Rs 150/-	53.00	B1.1.3.7.4	
2	CUG SIM Recurring Cost	35356	Rs 1200/- (Rs.200 per Month budgeted for 6 months)	424.27	B1.1.3.7.4	

Awards for ASHAs : Performance of ASHAs can be assessed on certain key activities based on which their efforts to improve status of health and its determinants can be reviewed. Every year states could select one best performing ASHA in each district based on the criteria given above and provide an additional amount of Rs 10000 as an award and one ASHA in each Talukas an amount of Rs 5000.

Sl no.	Programs	No. of Units	Unit cost	Amount proposed	Line Item Number	Remarks
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1	ASHA Awards District	30	Rs.10000	3.00	B1.1.4	
2	ASHA Awards Block	176	Rs 5000/-	8.80		

NEW ASHA DAIRY:

JUSTIFICATION : To develop dairy writing habit among ASHA to keep track of her activities like registering of ANC's, monthly planning, tracking of due services. Printing Brochures, Modules, Diary for ASHAs: Printed IEC materials, are a pre requisite to conduct any training.

DELIVERABLES: Ashas are not required to keep any additional records, or submit filed formats but use their register and Dairy, which are their planning and recording tools. This helps to ensure that reporting is reliable.

Sl no.	Programs	No. of Units	Unit cost	Amount proposed	Line Item Number	Remarks
1	Printing of Asha Diary		257		B 1.1.3. 6.1	
2	Printing of modules and brochures				B 1.1.3. 6.2	

BUDGET SUMMARY

S. No.	Budget Head	TOTAL PROPOSED (Apr 2014- Mar 2015)	
		Quantity / Target	Budget (Rs. Lakhs)
RCH			
A.1.3.4	Incentives to ASHA		
NRHM			
B1	ASHA		
B 1.1	ASHA Cost:		
B1.1.1	Selection & Training of ASHA		
B1.1.1.1	Module I - IV		
B1.1.1.2	Module V		
B1.1.1.3	Module VI & VII		
B1.1.1.4	Other Trainings		
B1.1.1.4.1	Two days Training for District Programme officers on HBNCC	60	3
B1.1.1.4.2	Bi-monthly review meeting of ASHA Mentors	236	3.54
B1.1.2	Procurement of ASHA Drug Kit		
B1.1.2.1	New Kits		
B1.1.2.2	Replenishment		
B1.1.2.3	Procurement of ASHA HBNC Kit		
B1.1.2.4	New Kits		
B1.1.2.5	Replenishment		
B1.1.3	Performance Incentive/Other Incentive to ASHAs (if any)		
B1.1.3.1	Incentive under MH (ANC/PNC)		
B1.1.3.1.1	HIV		
B1.1.3.1.2	Motivating Safe abortion		
B1.1.3.1.3	Other performance Incentives		
B1.1.3.2	Incentive under CH		
B1.1.3.2.1	Follow up of PNC		
B1.1.3.2.2	SNCU		
B1.1.3.2.3	Infant death		
B1.1.3.3	Incentive for FP(PPIUCD/others)		
B.1.1.3.4	Adolescent Health incentives		
B.1.1.3.4.3	Incentive for National Iron Plus Initiative		
B1.1.3.5	Other incentive		
B1.1.3.5.1	Other incentive		
B1.1.3.6.3	Support to ASHA		
B1.1.3.6.4			

B1.1.4	Awards to ASHA's/Link workers		
B1.1.5	ASHA Resource Centre/ASHA Mentoring Group		
B1.1.5.1	HR at State Level		
B1.1.5.2	HR at District Level	30	54.00
B1.1.5.3	HR at Block Level	176	274.56
B1.1.5.4	Mobility Costs for ASHA Resource Centre/ASHA Mentoring Group (Kindly Specify)		
IMMUNISATION			
C.1.g	Focus on slum & underserved areas in urban areas/alternative vaccinator for slums		
C.1.h	Mobilization of children through ASHA or other mobilizers		
C.5	ASHA Incentive		
	GRAND TOTAL (A+B+C)		

B.2 Untied Fund, Annual Maintenance Grant, Arogya Raksha Samithi/Rogi Kalyana Samithi Fund and Corpus Grant:

Introduction:

Prior to the advent of NHM/NHM, health institutions were in dire straits with lack of basic amenities due to lack of resources for contingency expenses and lack of decision making at the local level and not involving the stake holders in deciding the services to be made available at health institutions. To address these issues NHM has reserved funds at the disposal of health institutions with decision making power at their own level in the form of Untied Fund, Annual Maintenance Grant, Arogya Raksha Samithi/Rogi Kalyana Samithi fund/Corpus Grant.

NHM's main objective is to make the community own health institutions and to involve themselves in decision making regarding health planning and deciding the services to be made available at health institutions. Untied Funds are made available at VHSCs, Sub Centers, PHCs, CHC, and Taluk Level Hospitals. Untied Funds are meant to be utilized as per the requirement of the local issues and are not tied, with decision making power vested with the local ARS/RKS.

At VHSC level Untied Fund is operated through a joint account of that particular Village Gram Panchayat Member who is the president of that VHSNC and ASHA who is the Member Secretary. At Sub Center ANM is the Member Secretary of the Untied Fund account, at PHC, CHC/Taluk Level Hospital and District Hospitals the fund is operated through ARS.

At VHSC and Sub Center level, Untied Fund can be utilized for basic health delivery services such as conducting Health Surveys, arranging referral transport to pregnant women during labor, control of local epidemics, to ensure proper drainage, to provide privacy to patients who seek treatment at Sub Centers/VHNDs, to act as a revolving fund to provide loan to be repaid in installments to BPL, SC & ST and women self-help group members. This fund can also be used for the treatment of very poor families and destitute. At PHC, CHC, Taluk Level Hospitals Untied Fund can be utilized with approval of ARS for day to day activities of the health institutions like providing privacy to patients who seek treatment, to procure basic equipment, to arrange referral transport to pregnant women, to clean Hospital premises, to provide patient friendly amenities like drinking water, seating arrangements, hot water facilities, alternate power supply, procurement of emergency drugs and other local necessities.

Sub Centres, PHCs and CHCs/Taluk Hospitals have been provided Annual Maintenance Grant for the maintenance of Government buildings which can be utilized for minor repairs of the hospital buildings, to ensure water and electricity

supply, painting the buildings and to ensure regular upkeep of the health institutions

PHC and CHC/Taluk Hospitals have also been provided ARS/RKS funds which is being utilized for community needs like organizing Community Health Days, and other outreach activities in difficult to reach areas or in areas where vulnerable section of the society such as SC & ST, BPL, migratory populations and other such communities live. ARS fund is also being used for community based programmes like creating awareness and improving BCC. It is also being used for taking up communicable disease prevention or control measures during epidemics or impending epidemics. Untied, AMG and ARS Funds is being utilized with approval of ARS/RKS or ratified by ARS/RKS.

District Hospitals and Major Women and Child Hospitals have been provided Rs 5 lakhs as Corpus Grant every year, this fund is operated through ARS account. This fund is utilized for providing basic patient friendly amenities, procuring basic equipment, emergency drugs and linen, to arrange referral transport, for maintenance of the hospital building, ensuring alternate power supply, electric repairs and water supplies and other activities related to treatment of patients.

Activity Proposed: Provision of Untied Fund, Annual Maintenance Grant and Aarogya Raksha Samithi/Rogi Kalyana Samithi funds

Name of the Activity: Untied Fund, Annual Maintenance Grant and Aarogya Raksha Samithi funds for various Health institutions / Sub centre & VHSNC

This is a continued activity

Achievements: Untied Fund utilization of VHSNCs was 79% during 2012-13 and of PHCs, CHCs was 90-92%. AMG utilization of SCs, PHCs and CHCs was between 89-95% and RKS fund utilization of PHCs, CHCs and District Hospitals was 91-94 % during 2012-13

UNTIED FUND					
(Provisional Expenditure upto Nov-2013 for the FY 2013-14)					
Institution	No of Units	Unit Cost (Rs)	Budget approved	Expenditure up to end of Mar 2014	% up to end of 2014
VHSC	26084	10,000	2096.27	1633.76	79.28
Sub Centre	8811	10,000	736.03	624.11	86.38
PHC	2286	25,000	513.87	478.04	93.99
CHC	326	50,000	150.99	142.24	91.86

ANNUAL MAINTENANCE GRANT (Provisional Expenditure upto Mar-2014 for the FY 2013-14) Rs. in lakhs					
Institution	No of Units	Unit Cost (Rs)	Budget release d (in lakh Rs)	Expenditure up to end of Mar 2014	% up to end of 2013-2014
Sub Centre	5001	10,000	396.28	277.04	71.95
PHC	2182	50,000	967.48	877.77	90.40
CHC	326	1,00,000	299.71	271.94	91.29

AAROGYA RAKSHA SAMITHI/ROGI KALYANA SAMITHI FUND (Provisional Expenditure upto Mar-2014 for the FY 2013-14) Rs. in lakhs					
Institution	No of Units	Unit Cost (Rs)	Budget release d (in lakh Rs)	Expenditure up to end of Mar 2014	% up to end of 2013-2014
PHC	2194	1,00,000	1926.85	1799.22	94.26
CHC/Taluk Hospital	326	1,00,000	293.30	309.42	99.91
District Hospitals	19	5,00,000	126.77		
MCH Hospitals	8	5,00,000		110.87	90.24

Justification: During the last 4-5 years provision of Untied Fund, AMG and RKS funds have vastly improved the patient friendly amenities, improved the maintenance of facilities and have also improved the supply of emergency drugs, referral transport, IEC, community participation and community ownership of the facilities and health services. Provision of these funds from NHM has improved the vital health indicators of the State to appreciable levels. All the funds released to the facilities from the State Government is tied and user funds generated in some of the institutions are not adequate for day to day activities. Hence, the provision and continuation of these funds is justified for providing quality services to the poor and to reduce their out of pocket expenditure (OOPS).

Deliverables: Creating patient friendly amenities at health facilities and providing quality health care services free of cost to reduce out of pocket expenditure of the poor and reversing the trend of movement of patients from private to public facilities.

Funding Proposed:

In the State there are 10 separate Maternity and Child Health Hospitals and 2 General Hospitals in Bangalore City in addition to the District Hospitals which are catering to a large number of mother and child beneficiaries and separate Corpus Grant is necessary for maintenance of these Hospitals on similar grounds as District Hospitals. Hence, Corpus Grant (Untied Fund) of Rs.10.00 lakhs is proposed during 2014-15 for 12 such hospitals.

From 2014-15, United Fund, AMG and RKS funds have been merged and is now called as **"Untied Funds"**. Under NHM, the budget provision of Untied Fund for CHCs and District Hospitals have been doubled from 2014-15. Hence, the Untied Fund for CHCs and District Hospitals has been proposed at new rates.

Untied Fund, AMG and ARS/ RKS fund:

Sl. No.	Activity	No. of units	Unit cost (in Rs.)	Amount proposed (in lakhs)	FMR code
1	District Hospital	27	10,00,000	270.00	B2.1
2	Taluka hospital	146	5,00,000	730.00	B2.2
3	CHC	188	5,00,000	940.00	B2.3
4	PHC	2350	2,50,000	5875.00	B2.4
5	Sub Centre	8871	20,000	1774.20	B2.5
6	VHSNC	26084	10,000	2608.40	B2.6
	Total			12197.60	

B.4. and B.5. Hospital strengthening and New construction:

Ongoing works:

B4.1.1.1(A) Construction of District hospital at Ramnagar:

Construction of District hospital at Ramnagar has been approved as spill over work in NRHM PIP for the year 2013-14 at a total project cost of Rs.2500 Lakhs and with an approved grant of Rs.300 lakhs. The Land required for the construction of District Hospital Ramnagar has been identified in the heart of the town to provide health facilities to the public. This land belongs to Karnataka Public works, Ports and Inland water Transportation Department.

The process for transferring of identified land to Health and Family Welfare Department from Karnataka Public works, Ports and Inland water Transportation Department is in progress. However, efforts are being made to avail the required extent of land for the above work in the current financial year.

The work of construction of District Hospital at Ramnagar could not be taken up due to non-availability of the required extent of land during the year 2013-14. Therefore, this work has been projected as a spill over work in the PIP 2014-15 at a project cost of Rs.2700 lakhs and the grant requirement for the current year is Rs.300 lakhs.

B4.1.1.1(B) Construction of District Hospital at Yadgir:

Construction of District hospital at Yadgir has been approved as spill over work in NRHM PIP for the year 2013-14 at a total project cost of Rs.2500 Lakhs and with a approved grant of Rs.300 lakhs. A private land measuring an area of 29 acres 28 guntas for the construction of District Hospital Yadgir has been identified in Yadgir town to provide health facilities to the public.

The Yadgir District Administration has been requested to acquire the land and transfer to the Health Department. The efforts are being made to avail the required site for the above work in the current financial year itself.

The work of construction of District Hospital at Yadgir could not be taken up due to non-availability of the appropriate site during the year 2013-14. Therefore, this work has been projected as a spill over work in the PIP 2014-15 at a project cost of Rs.2700 lakhs and the grant requirement for the current year is Rs.300 lakhs.

B4.1.1.3 (A) Construction of New Government HSIS Ghosha Women and Children Hospital at Shivajinagar, Bangalore:

The work of construction of New Government HSIS Ghosha Women & Children Hospital at Shivajinagar, Bangalore has been taken up as a spill over

work at a project cost of Rs.1299.15 lakhs and the work has been started on 15.02.2012 with a contract period of 18 months.

This work consists of construction of three blocks and has been taken up on phased manner, as the existing hospital is a functioning one and care has been taken to provide health facilities to the public even during the construction activities is in progress. Since the hospital is located in heart of the Bangalore city, the mobilization of materials, men etc., is to be carried out in the late hours. Because of the above facts the construction work is getting delayed, which is supposed to be completed by 14.06.2014. However, the efforts have been made to complete the work by September 2014.

This work has been projected as a continued activity with required grant of Rs.22.38 lakhs in the PIP 2014-15.

B4.1.1.3 (B) Construction of District Hospital at Chickaballapur:

Construction of District hospital at Chickaballapur has been taken up during 2012-13 at a total project cost of Rs.2224 lakhs with a contract period of 24 months including monsoon period. The Hospital construction consists of 4 blocks.

The Financial progress achieved is Rs.1500 lakhs by end of March 2014. The stipulated date of completion of the work is 17.09.2014. The balance amount of Rs.724 lakhs is required for completion of the work. This amount is proposed in the 2014-15 PIP under spillover works.

B4.1.2.3 Upgradation of CHC at Kamalnagar in Bhalki Taluk Bidar

District:

The work of Upgradation of CHC at Kamalnagar in Bhalki Taluk, Bidar District has been approved under Supplementary PIP-II for the year 2013-14 during November 2013 with a approved grant of Rs.125 lakhs for the year 2013-14. After completion of the tender process and code of conduct of parliamentary elections, the work order has been issued to the Contractor at a contract value of Rs.408.05 lakhs during May 2014 with a stipulated period of completion of 18 months including monsoon season. Hence, this work has been projected in the PIP 2014-15 as an ongoing spill over work with a required grant of Rs.188.05 lakhs.

B4.1.3.3 Construction of 64 Primary Health Centres:

The Construction of 58 Primary Health Centres have been approved as ongoing works during 2013-14 with an approved grant of Rs.3453.89 lakhs for the year. Out of these 58 works 18 works were approved during 2010-11 and 40 during 2012-13. 19 works are completed and 39 works are nearing completion with a total required grant of Rs.2660.35 lakhs. In addition to this 82 PHCs

which were taken up during 2010-11 and completed during 2011-12 and 2012-13 were not projected for the requirement of grant under completed works. A grant of Rs.982.56 lakhs is required for settlement of final claims of the works, hence the same is projected under PIP 2014-15.

The Construction of 6 Primary Health Centres in Gulbarga and Belgaum revenue divisions have been approved under Supplementary PIP-II for the year 2013-14 during November 2013 with a approved grant of Rs.240 lakhs for the year 2013-14. After completion of the tender process and code of conduct of parliamentary elections, the work order has been issued to the Contractor at a contract value of Rs.704.18 lakhs during May 2014 with a stipulated period of completion of 18 months including monsoon season. Hence, this work has been projected in the PIP 2014-15 as an ongoing spill over work with a required grant of Rs.282.23lakhs for the current year and Rs.421.95 lakhs for the financial year 2015-16.

B4.1.4.3 Construction of ANM Sub Centres:

The Construction of 277 ANM Sub Centres have been approved as ongoing works during 2013-14 with an approved grant of Rs.4542.07 lakhs for the year. Out of these 63 works were approved during 2010-11 and 214 during 2012-13. 54 works are completed and 182 works are nearing completion with a total required grant of Rs.2696.39 lakhs. 41 works were proposed to be dropped because of non-availability of appropriate site for construction. In addition to this 169 ANM Sub Centres which were taken up during 2010-11 and completed during 2011-12 and 2012-13 were not projected for the requirement of grant under ongoing works. Out of these 143 works have been completed and 26 works are nearing completion for which the sites were made available during 2012-13. A grant of Rs.660.28 lakhs is required for settlement of final claims of these works, hence the same is projected under PIP 2014-15.

B4.1.5.3 Construction of MCH Wings at District Hospital and District Level Hospitals:

The Construction of 10 MCH Wings at District Hospital and District Level Hospitals were approved in the PIP 2013-14 during June 2013 with a total grant of Rs.3060 lakhs. After completion of the approvals and the tender process the works have been entrusted to contractors during March 2014 with stipulated period of 24 months including monsoon season. MCH Wing at Gowribidanur Taluka Level Hospital in Chickkaballapur Taluk is approved under Supplementary III PIP for the year 2013-14 during March 2014 with a total project cost of Rs.1574 lakhs including equipments with a earmarked grant of Rs.100 lakhs for the 2013-14. This work is yet to be started after obtaining the approvals and tender process.

Thus the constructions of 11 MCH Wings at District/District Level Hospitals have been projected as spill over works with required grant of Rs.5452.15 lakhs during the year 2014-15.

The Construction of MCH block and labour ward at K.C.General Hospital, Bangalore was approved during 2009-10 and the work has been completed during 2012-13 with a total project cost of Rs.202.40 lakhs. For final settlement of the claims of the contractor a grant of Rs.27.02 lakhs is required and the same is projected in the PIP 2014-15. Thus the total grant required during 2014-15 for 12 numbers of MCH Wings is **Rs.5479.17 lakhs**.

B5.10.1.3 Repairs, Renovation and Upgradation of District/ANM/Health & Family Welfare Training Centres.

Repairs, Renovation and Upgradation of 13 District/ANM/Health & Family Welfare Training Centres were approved in the State Supplementary PIP-IV, RCH Flexi pool for financial year 2012-13 at project cost of Rs.229.65 lakhs. Out of these 12 works have been completed and one is nearing completion with a total contract value of Rs.210.17 lakhs. The grant required for completion and settlement of final bills during the year 2014-15 is Rs.46.60 lakhs.

Repairs, Renovation and Upgradation of 11 District/ANM/Health & Family Welfare Training Centres were approved in the PIP 2013-14 at project cost of Rs.655 lakhs with a grant of Rs.375 lakhs. Out of these 11 works one work at Karwar and another ANM Training work at Gulbarga were dropped on the suggestions of the concerned District Health Officers as the proposal for construction of new buildings is in process. Out of the remaining 9 works till date one work is completed and the remaining 8 works are under construction. The grant required for these 9 works for the year 2014-15 is Rs.430.76 lakhs.

The total grant required for completion of 22 works is Rs.477.36 lakhs during the year 2014-15 and the same is projected in the PIP 2014-15 as spill over works.

B4.1.5.4.1 Construction of intermediate referral Laboratory:

Construction of intermediate referral Laboratory and providing interiors for Training Hall, laboratory Rooms at First Floor of Intermediate Referral Laboratory in the premises of SDS, TB & RGICD Campus, Someswaranagara, Bangalore has been approved in the PIP 2013-14 at a total project cost of Rs.67.50 lakhs. The construction activity is nearing completion and the interiors works are to be taken up. The work is expected to be completed during October 2014. The grant proposed in the PIP 2014-15 is Rs.35.42 lakhs for completion.

New Proposals for 2014-15

B4.1.5.1

1. Construction of 60 Beds MCH Wing at District hospital Chitradurga:

The existing District hospital at Chitradurga caters to the health needs of around 1.60 lakhs population covering the entire block. At present, the hospital is having total bed strength of 40, upto April 2013 as per HMIS data, average OPD load per month is 4500 while IPD load per month is 430 with Average Bed occupancy of 100.

Since, the bed occupancy is more than the available beds in the hospital, State proposes to expand the maternity section with an additional 60 beds. This will help in bringing ANC cases 24 hours in advance and ensuring that the post natal mothers and new born baby to stay for 48 hours.

Hence a proposal is put up for expansion of MCH wing with a budget requirement of Rs. 180 lakhs for 2014-15, Rs.570lakhs for 2015-16 and Rs.395lakhs for 2016-17. Total project cost is 1415lakhs with a construction period of 24 Months including construction of 4 Doctors, 6 Nurse and 4 Group-D staff quarters and cost of necessary equipments.

2. Construction of 100 Beds MCH Wing at Women and Child hospital

Davangere:

The existing hospital caters to the health needs of around 19.45 lakhs population covering the entire block. At present, the hospital is having total bed strength of 100, upto April 2013 as per HMIS data, average OPD load per month is 3521 while IPD load per month is 712 with Average Bed occupancy of 3040.

Since, the bed occupancy is more than the available beds in the hospital, State proposes to expand the maternity section with an additional 100 beds. This will help in bringing ANC cases 24 hours in advance and ensuring that the post natal mothers and new born baby to stay for 48 hours.

Hence a proposal is put up for expansion of MCH wing with a budget requirement of Rs. 210lakhs for 2014-15, Rs.700lakhs for 2015-16 and Rs.505lakhs for 2016-17. Total project cost is 1415lakhs with a construction period of 24 Months including construction of 4 Doctors, 6 Nurse and 4 Group-D staff quarters and cost of necessary equipments.

3. Construction of 100 Beds MCH Wing at District Hospital Dharwad:

District hospital caters to the health needs of around 2.56 lakhs population covering the entire block. At present, the hospital is having total bed strength of 250, upto April 2013 as per HMIS data, average OPD load per month is 18750 while IPD load per month is 1283 with Average Bed occupancy of 150.

Since, the bed occupancy is more than the available beds in the hospital, State proposes to expand the maternity section with an additional 100 beds. This will help in bringing ANC cases 24 hours in advance and ensuring that the post natal mothers and new born baby to stay for 48 hours.

Hence a proposal is put up for expansion of MCH wing with a budget requirement of Rs. 210lakhs for 2014-15, Rs.700lakhs for 2015-16 and Rs.505lakhs for 2016-17. Total project cost is 1415 lakhs with a construction period of 24 Months including construction of 4 Doctors, 6 Nurse and 4 Group-D staff quarters and cost of necessary equipments.

4. Construction of Additional floors for Upgradation of HSIS Gosha Women and Child Hospital from 150 to 300 Bed Hospital at Shivajinagar, Bangalore:

Hence a proposal is put up for upgradation of MCH wing with a budget requirement of Rs.280lakhs for 2014-15, Rs.925lakhs for 2015-16 and Rs.645 lakhs for 2016-17. Total project cost is 1850 lakhs.

B5.2.1 Construction of 14 Primary Health Centres in Gulbarga Revenue Division and 1 in Honnavara taluka, Uttara Kannada District:

The construction of 14 Primary health Centres are to be taken up in the remote villages of Gulbarga Revenue Division spread over Raichur, Koppal, Bellary and Yadgir Districts which comes under High Focus Districts to provide better health care facilities to the villages as well as the surrounding remote villages. These works have been proposed by the concerned District Health officers.

One Primary health Centre is to be established in the Kadathola village of Honnavara taluka, in Uttara Kannada District to provide the health care facilities to the surrounding remote villages. The cost of the construction of each primary health centres has been workedout based on the approved typical plan which is in practice prepared by KHSDRP and the applicable schedule of rates of concerned Public Works Department circle. The total project cost for construction of 15 primary health centres is Rs.1805lakhs with a construction period of 15 months. The projected budget for the year 2014-15 is Rs.300lakhs and for the year 2015-16 is Rs.1505lakhs.

B. 9. MAINSTREAMING OF AYUSH UNDER NRHM

INTRODUCTION:

The Department of ISM&H renamed in Nov 2003 as Department of AYUSH with a view to providing Health care, education and Research in Ayurveda, Yoga & Naturopathy, Unani, Siddha, Homeopathy systems. The Department continued to lay emphasis on improving health care facilities, upgrading AYUSH educational standards, quality control, standardization of drugs, improving medicinal plants research and development, awareness generation about AYUSH. The Karnataka has taken initiative in Mainstreaming of AYUSH in National Health Care under NHM in right earnest.

The AYUSH systems are time-tested methods to tackle life style disorders, which are becoming a major threat to health in present era. These systems can play major role not only in preventing the diseases but in curative aspects also. AYUSH system can give a holistic approach to health care to the poor especially in rural areas. In the above view it is necessary to Popularize, Revive, Revitalize, the AYUSH system by giving proper infrastructure, Human Resource Development, capacity building. AYUSH systems of Medicines are well accepted by community particularly in rural areas because these are mostly traditional, safe and efficacious and easily available which can be prepared locally by the available resources. Some of them are also home remedies.

SITUATION ANALYSIS:

The Department of AYUSH is rendering effective services in health care preventive, curative, promotive and rehabilitative care. It has got its own health services wing in all the systems of medicine and has got its medical education department, drug manufacturing unit, drug licensing authority and registration board to assist in health care delivery system.

The Director of AYUSH is assisted by one Joint Director for Medical Education, three Deputy Directors, one each for Ayurveda, Unani, & Homeopathy, & Yoga, an Administrative officer, and an Accounts Officer, in the Directorate. The Districts will be headed by District AYUSH officers to implement and monitor the programmes at a regular interval. The whole team of these officers will be controlled by the Commissioner of Health & Family Welfare, Government of Karnataka.

Health Infrastructure:

There are 103 AYUSH hospitals with 1545 bed strength and 659 dispensaries functioning in this State as on 01-12-2014. The system wise details are as below:-

SL No	Systems	Government Hospitals		No. of Dispensaries
		No. of Hosp	No. of Beds	
1	Ayurveda	91	1522	562
2	Unani	12	212	50
3	Homoeopathy	13	220	43
4	Nature Cure	03	26	05
5	Yoga	03	15	0
TOTAL		122	1995	660

The Staff Position of the Department is as follows:-

	Non Teaching			Teaching			Total		
	S	W	V	S	W	V	S	W	V
Group-A	138	100	38	189	93	96	327	193	134
Group-B	882	748	134	114	58	56	996	806	190
Group-C	957	451	506	0	0	0	957	451	506
Group-D	1332	837	495	0	0	0	1332	837	495
TOTAL	3309	2136	1173	303	151	152	3612	2287	1325

Man Power:

The manpower at the AYUSH Directorate and various other health facilities are not fully positioned, more than 25% of post are vacant. Hence it is a hindrance for effective implementation of NRHM programmes. Thus it is imperative to fill up the existing vacant posts and propose some of the posts which are needed to be filled under NRHM component manpower is proposed on a need basis.

The requirement of additional staff is proposed in the PIP 2014-15

Budgetary out lay for the year 2013-14 is as follows:

(Rs. In lakhs)

	State Sector		District Sector	
	Budget Estimates	Expenditure (up to Jan 2014)	Budget Estimates	Expenditure (up to Jan 2014)
PLAN	6018.00	3440.00	845.19	635.00
NON-PLAN	6022.39	4681.00	7143.48	5680.00
C.S.S.*	0	0	0	0
TOTAL	12040.39	8121.00	7988.67	6315.00

*** For CSS PIP submitted for Rs.1596.52 lakhs. Budget approval is awaited for 2013-14.**

The budgetary provision comes from plan & non plan expenditures and some of the budgetary provisions born under CSS & NRHM. The allocations under budgetary provisions to are not sufficient to provide health care services. The infrastructure and manpower has also to the supplemented.

Quality Control

The number of licenses issued to manufacture of Ayurveda, Unani and Homoeopathy medicines as on 01-12-2013 are as follows:-

Systems	No. of Manufacturing license holders.	Loan license	No. of Sales	
			Whole sale	Retail
Ayurveda	193	96	0	0
Unani	01	0	0	0
Homoeopathy	10	0	70	162
Total	204	96	70	162

Regulatory authorities : Statutory Boards:

There are two statutory boards namely the Karnataka Ayurveda and Unani Practitioner's Board and the Karnataka Homoeopathy practitioner's Board. Number of practitioners in various systems of medicine has been registered in these boards. Details are as follows:-

Systems	No. of practitioners registered
Ayurveda	29946
Unani	1624
Integrated systems	2423
Naturopathy & Yoga	460
Siddha	04
Homoeopathy	11907
TOTAL	46364

Medical Education Sector

The details of Medical Colleges under this Department are as follows:-

System	Government		Private				Total No. of Govt. & Pvt. Colleges	
			Aided colleges		Unaided Colleges			
	No.	Intake	No.	Intake	No.	Intake	No.	Intake
Ayurveda	04	210	05	310	50	2320	59	2840
Unani	01	50	0	0	03	120	04	170
Homoeopathy	01	40	0	0	10	740	11	780
Yoga & Nature Cure	01	25	0	0	03	200	04	235
Total	07	325	05	310	66	3390	78	4025

OBJECTIVES:

Main objective of AYUSH mainstreaming is to provide Holistic comprehensive health care services which are affordable, accessible to those in rural areas, poor & vulnerable groups especially the women and children

STRATEGIES:

- Strengthening of the grass root level Health service providers to the ASHA's, VHSC's, SHGs.
- Strengthening of the existing rural dispensaries by providing adequate infrastructure, Manpower, Equipments, & Drugs.
- Mainstreaming of AYUSH in the PHC's, FRU's, CHC's, Taluk Hospitals, District Hospitals, by providing necessary basic infrastructure so that the patient can have more choice to select the system of their choice.
- Functionalization the Panchakarma units in all the Districts hospitals.
- Creation of awareness about the AYUSH systems in general public and make a patient people friendly policy.
- Re-orientation for medical and paramedical personals.
- Promotion community participation in AYUSH system.
- To emphasize the grey areas such as Skin care, Neurological, disorders, Mother & Child Care ANC, PNC, Mental Health etc.
- Promotion of Home remedies to take care of Primary Health care at Home level with minimal cost or no cost.
- Promotion of AYUSH Grama & Yoga.
- Awareness programme through IEC activities such as print media, Electronic Media, Campaigns, Workshops and Meeting etc.
- Revitalization of local Health traditions through NRHM programmes.
- Involvement of NGO's and Govt organization and other local resources for implementation programme

Activities Proposed:**Remuneration of AYUSH Doctors working at 24 x 7 PHC / CHC / TH. / DH.**

It is a continued activity.

Karnataka State AYUSH department appointed 650 AYUSH doctors under NRHM to cater the needs of the patient at 24 x 7 PHC / CHC / Taluka Hospital / District hospital since 2006. Presently there are 650 AYUSH doctors working at various facilities which are identified as delivery points. All the AYUSH doctors of various streams of AYUSH viz., Ayurveda, Yoga, Unani, Homoeopathy are giving primary Health Care according to the choice of the patient and providing a holistic approach to health, in rural areas. As per the road map shown in the ROP 2013-14, all AYUSH doctors are participating and providing necessary assistance in all National programmes.

AYUSH doctors under NRHM contract are paid Rs.14,000/- pm. As per 6th Pay Commission contractual AYUSH doctors working in state sector receive Rs.28,000/- per month (since April 2013). This has created a wide gap. Hence the State proposes Rs.28,000/- for contractual AYUSH doctors under NRHM for the year 2014-15.

Justification:

Continuation of AYUSH Doctors is necessary as they fill the gap wherever demand is there for Indian system of medicine in rural areas.

Funding Proposed:

Sl. No.	Activity	No of Units*	unit Cost	Amount proposed	FMR code
1	Remuneration for AYUSH Doctors	650	0.28	2184.00	B-9.1.4

Activity Proposed: Human Resource other than AYUSH doctors including state wing

HR is proposed for the following units:

- State Programme Management Unit.
- 36 Yoga & Naturopathy units.
- 13 Panchakarma units.
- 27 computer operator for districts.
- 250 Cleaning personnel for health institutions.

The above contractual manpower is hired since FY 2009

SPMU:

Management unit is established at state level to carry out AYUSH activities under NRHM. The following persons are hired on contract viz. one accounts assistant, three data entry operators, two multipurpose workers & one programme manager. State SPMU is responsible for preparation of programme implementation plan, preparing guidelines as per approved ROP, consolidation of reports on programme from districts, organizing meetings and other activities. The budget required for SPMU is shown in Annexure-2.

Man power / Admin. Cost : State level								
Sl. No	Category	Existing staff in 2013-14 (Approved by GoI)			Proposed staff in 2014-15			Remarks / Justification
		No. of existing staff	Salary per month	Amount approved (Rs. In lakhs)	No. of staff proposed	Salary per month	Amount approved (Rs. In lakhs)	
1	Account Assistant	1	12000	1.44	1	14000	1.68	Existing Post Rs.2000/- hiked according to inflation.
2	Data entry operator	4	10000	4.80	3	12000	4.32	Existing Post Rs.2000/- hiked according to inflation.
3	Group D	2	6500	1.56	1	8000	0.96	Existing post Rs.1500/- is proposed for enhancement.
4	Programme Manager	1	25000	3.00	1	25000	3.00	Existing post.
6	Driver	1	10000	1.20	1	12000	1.44	Existing Post Rs.2000/- hiked.
7	Administrative Expenses	1		10.00	1		15.00	Enhanced Rs.5.00 lakhs.
	Total			22.00	44		26.40	

YOGA & NATUROPATHY UNITS:

Yoga & Naturopathy Units are an innovative activity of the State under PPP mode started from FY. 2009-10. Yoga & Naturopathy centers at 11 Taluk Hospitals with the help of Shantivan Trust, Ujjire are functioning as co-located units. The manpower for the above units is from NRHM and infrastructure & drugs are provided under CSS. The hospitals are in Sringeri, Thirthahalli, Puttur, Sankeshwara, Kanakapura, Hosdurga, Jagaluru, Chararajanagara, Srirangapatna, Arsikere & Legislators House, Bangalore. These units are providing primitive, promotive, curative services at the center. Each center has six personnel including medical & para-medical staff. Most of the centers are specialized in treating musculo-skeletal disorders, mental disorders like anxiety, depression and stress. These centers also provide training to school children about yoga & naturopathy. Obesity clinics, Stress clinics, Yoga clinics are most popular units in these centers.

Table showing patient load in each center

Name of the center	Patient Average per day
Sringeri	45-50 per day
Thirthahalli	35-40 per day
Puttur	50-60 per day
Sankeshwara	40-50 per day
Kanakapura	70-80 per day
Hosdurga	60-70 per day
Jagaluru	40-50 per day
Chararajanagara	40-50 per day
Srirangapatna	70-80 per day
Arsikere	40-50 per day
L.H. Bangalore	20-30 per day

Funding proposed **Cost of one Unit:**

Sl. No	Category	Existing staff in 2013-14 (Approved by GoI)			Proposed staff in 2014-15			Remarks
		No. of existing staff	Salary per month	Amount approved (Rs. In lakhs)	No. of staff proposed	Salary per month	Amount approved (Rs. In lakhs)	
1	Medical Officer Yoga Naturopathy	1	13000	1.56	1	28000	3.36	enhanced Rs.28,000/-
2	Therapist	2	10000	2.40	2	12000	2.88	enhanced Rs.12,000/-
3	Cleaning Staff	2	6500	1.56	2	8000	1.92	enhanced Rs.8,000/-
4	Receptionist	1	9000	1.08	1	10000	1.2	enhanced Rs.10,000/-
	Total			6.60			9.36	

PROPOSAL FOR NEW CENTERS:

During 2014-15, 25 new centers are proposed. These centers are to be located in high priority districts, naxalite affected districts and tribal districts. On public demand.

Total budgetary requirement for 36 units x Rs.9.36 lakhs per unit = Rs.336.96 lakhs.

PANCHAKARMA UNITS :

Panchakarma units were established in Fy. 2009-10. These centers are co-located in district hospitals. The objective is to provide specialized panchakarma therapies for chronic diseases. Each center has 7 contractual manpower including two post graduate doctors and five para-medics. Various therapies like Vamana, Virechana, Basti, Rakta mokshana & various Keraliya procedures are provided. Average patient load in each center is shown below.

Table showing name of the center with average patient per day

Name of the center	Patient Average per day
Belgaum	30-40 per day
Dharwad	35-40 per day
Haveri	40-50 per day
Gulbarga	40-50 per day
Chitradurga	35-40 per day
Davanagere	40-50 per day
Raichur	40-50 per day
Udupi	40-50 per day
Shimoga	35-40 per day
Kolar	35-40 per day
Hasan	35-40 per day
Chikkamagalore	35-40 per day
L.H. Bangalore	35-40 per day

Cost of one Unit

Sl. No	Category	Existing staff in 2013-14 (Approved by GoI)			Proposed staff in 2014-15			Remarks
		No. of existing staff	Salary per month	Amount approved (Rs. In lakhs)	No. of staff proposed	Salary per month	Amount approved (Rs. In lakhs)	
1	Medical Officer Panchakarma	2	18000	4.32	2	35000	8.40	Enhanced to Rs.35,000/-
2	Staff Nurse	2	7500	1.80	2	10000	2.40	Enhanced to Rs.10,000/-
3	Therapist	2	10000	2.40	2	12000	2.88	Enhanced to Rs.12,000/-
4	Multipurpose worker	1	6500	0.78	1	8000	0.96	Enhanced to Rs.8,000/-
	Total			9.30			14.64	

Total budgetary requirement for 13 units x Rs.14.64 lakhs per unit = Rs.190.32 lakhs.

COMPUTER OPERATOR FOR DISTRICTS:

Computer operators will assist district AYUSH officer in day to day functioning and are working since Fy. 2009-10.

Total budgetary requirement for 27 operators x Rs.1.44 lakhs per year = Rs.38.88 lakhs.

CLEANING PERSONNEL FOR HEALTH INSTITUTIONS:

State has identified 250 AYUSH institutions which are collocated to provide health care services. Contractual cleaning personnel are hired on contract and their services are continued since Fy. 2009-10.

Total budgetary requirement for 250 Cleaning Personnel x Rs.0.24 lakhs per year = Rs.60.00 lakhs.

Funding Proposed:

Sl. No.	Name of the Man power	No of Units	Cost per unit	Total Cost in lakhs	FMR code
1	Remuneration of Computer Operator	27	1.44	38.88	B-9.2.7
2	Remuneration of Cleaning Personnel	250	0.24	60.00	
3	Remuneration of Panchakarma Unit Staff	13	14.64	190.32	
4	State Level Manpower	1 Unit	363.36	363.36	
Grand Total for HR other than AYUSH Doctors				652.56	

Activity Proposed: Training:

Various training programmes are being conducted to the health personnel to enhance their skills. It is a continued activity since FY 2009-10

PANCHAKARMA TRAINING:

A specialized 6 days panchakarma training for Ayurveda doctors working in PHC's / GAD/ TH / DH / is planned. So far 165 doctors have undergone training in the previous years. For 2014-15 two trainings are proposed in which 60 doctors are to be trained. This is an in-house training in which various techniques of Panchakarma are taught by experts in the field. The training includes practical demonstration also.

KSHARASUTRA TRAINING:

Ksharasutra is a specialized training in Ayurveda where treatment techniques are taught for disorders like piles, fistula etc. It is a 6 days training for AYUSH doctors working in PHC's /GAD/ TH / DH . So far 90 doctors are trained in the previous years. For 2014-15 one training programme is proposed for 30 doctors.

HOMOEOPATHY TRAINING:

It is a specialized 6 days training for AYUSH Homoeopathy Doctors working in PHC's / TH / DH / State AYUSH Institutions is planned in which a protocol for Mother & Child Care in Homoeopathic interventions is developed. .. Already more than 90 Doctors trained in the previous years. For 2014-15 one training programme is proposed for 30 doctors.

REGIMINAL THERAPY TRAINING :

Regiminal Therapy is a specialized 6 days training for AYUSH Unani Doctors working in PHC's /GAD/ TH / DH. Already more than 120 Doctors trained in the previous years. For 2014-15 one training programme is proposed for 30 doctors.

Table showing budgetary provision for all trainings in the year 2014-15

Training								
Sl. No.	Activity	Cumulative achievement as on 31st 2012	2013-14		2014-15			Remarks
			Planned	Achieved	Work plan	Scheduled trg. load	Budget (in lakhs)	
1	Panchakarma Training (05 days)	165	165	0	30x 2	60	6.04	Training will be done by reputed colleges selection by E.O.I. method.
2	Ksharasutra Training (06 days)	90	30	30	30x 1	30	3.02	
3	Homeopathy Training (06 days)	90	0	0	30x 1	30	3.02	
4	Regimental therapy (06 days)	90	0	0	30x 1	30	3.02	
	Total					150	15.10	

Activity Proposed: AYUSH Nutritional Programme

Child Malnutrition in Karnataka: Malnutrition is the underlying cause of at least 50 per cent of deaths of children under five. Even if it does not lead to death, malnutrition, including micronutrient deficiencies, often leads to permanent damage, including impairment of physical growth and mental development. For example, iron, folic acid and iodine deficiencies can lead to brain damage, neural tube defects in the newborn and mental retardation.

The findings of the third National Family Health Survey (NFHS-3) reveals an unacceptable prevalence of malnutrition in our children:

42.5% of our children under the age of five years are *underweight* (low weight for age)

48 % of our children are *stunted* (low height for age – chronically malnourished)

19.8 % of our children are *wasted* (low weight for height – acutely malnourished)

In poorer states the situation is even worse with over 50 % of children underweight

To supplement the nutritional level in food intake by children AYUSH department has initiated a nutritional supplementation programme. Under the programme anganwadi children are given 'AYUSH Pushti' biscuits in the form of cookies every day. The biscuits contain herbal medicinal properties of Balya, Medhya, Jeevaniya in nature which are having qualities of immunomodulator, anti-oxidant and nutritive value. It is accepted by children, palatable, cheaper, without any side effects.

It is a continued activity since FY 2012-13

Achievements:

During 2013-14 one Taluk in Bagalkote District was selected as a pilot for the programme. AYUSH Pushti Biscuits were distributed to 3000 Anganwadi children for six months. Records show an improvement in weight gain and enhancement in learning skills among these children.

Justification:

For 2014-15 it is planned to provide AYUSH nutritional supplementation to children in the same taluka in Bagalkot district.

Funding Proposed:

No of Units*	Cost per unit	Total Cost	FMR code
1 taluka	120.00	120.00	-

B. 10 . IEC/BCC

COMMUNICATION STRATEGY:

For the year 2014-15, Karnataka's NHM IEC PIP has laid more emphasis on IPC (interpersonal communication) and a series of activities which ensure there is interaction between the health educator/grass root worker and the community have been proposed under the respective programme headers. Apart from this mass media such as electronic and print media together with mid media such as outdoor media including folk media, exhibitions, etc. will also be employed.

It is proposed to recruit Health Educators (BHEOs) for the 8 HPD in Karnataka and training for to be recruited health educators has been planned and will form an integral part of our communication plan as these health educators are immensely and urgently required in these 8 High Priority Districts (HPDs) to support grassroots IEC/BCC activities. Trainings and workshops have been proposed to strengthen the workforce to contribute to the Communication Plan.

Major Topics Addressed	Audience	Content	Medium	Resources
Adolescent health	Target audience (primary, secondary, tertiary)	Adolescent changes both physical and mental, Danger signs of teenage pregnancy, unsafe abortion, menstrual hygiene risk of RTI/STI, malnutrition, anaemia	Use of <i>print media</i> such as posters, pamphlets/handouts, <i>IPC</i> - counselling, FGD, community meetings, <i>electronic media</i> -TV & Radio <i>Mid media</i> such as folk art and theatre, social and interactive media will also be employed	State IEC Wing, DHO, IEC staff – DHEO, BHEOs, THEOs, ANM, ASHA
ANC & PNC	Target audience (primary, secondary, tertiary)	Need for Immunization During pregnancy, pre natal care for mother, proper nutrition, proper medications and supplementation of IFA, ultra sound, danger signs of anemia during pregnancy. Need for post partum care, 48hrs stay after delivery, follow up visits for baby and mother, proper	Use of <i>print media</i> such as posters, pamphlets/handouts, <i>IPC</i> - counselling, FGD, community meetings, <i>electronic media</i> -TV & Radio <i>Mid media</i> such as folk art and theatre, social and interactive media will also be employed	State IEC Wing, DHO, IEC staff – DHEO, BHEOs, THEOs, ANM, ASHA

		nutrition and breast feeding and counseling family planning methods		
Family Planning	audience (primary, secondary, tertiary)	Adoption of contraceptive methods and sterilization procedures (tubectomy, NSV), use of PPIUCD and other spacing methods, Promotion of male participation	posters, pamphlets/handouts, <i>IPC</i> - counselling, FGD, community meetings, <i>electronic media</i> –TV & Radio <i>Mid media</i> such as folk art and theatre, social and interactive media will also be employed	
Institutional Delivery	Target audience (primary, secondary, tertiary)	Importance of Institutional Delivery, importance of post partum care, importance of 48hrs stay after delivery	Use of <i>print media</i> such as posters, pamphlets/handouts, <i>IPC</i> - counselling, FGD, community meetings, <i>electronic media</i> –TV & Radio <i>Mid media</i> such as folk art and theatre, social and interactive media will also be employed	State IEC Wing, DHO, IEC staff – DHEO, BHEOs, THEOs, ANM, ASHA
Immunization	Target audience (primary, secondary, tertiary)	Importance of Immunization, Vaccination for vaccine preventable diseases and school children immunization	Use of <i>print media</i> such as posters, pamphlets/handouts, <i>IPC</i> - counselling, FGD, community meetings, <i>electronic media</i> –TV & Radio <i>Mid media</i> such as folk art and theatre, social and interactive media will also be employed	State IEC Wing, DHO, IEC staff – DHEO, BHEOs, THEOs, ANM, ASHA

IMPLEMENTATION OF IEC/BCC

Existing Channels/Resources:

Directorate of Information: The Directorate of Information will be utilised to handle newspapers ads, press releases, tender notices etc. for the year 2014-15.

DD and AIR have been used for airing of TV & Radio spots on health issues respectively and for the year 2014-15 they will again be utilized. It is also proposed to air TV and Radio spots/ interviews/ discussions on private television channels too depending on their reach and TRP.

Local TV channels and FM radio stations: Local TV Channels have earlier been used to air the TV spots for a set timeperiod and the bills are paid at the end of the contract. Similarly, the same may be done for 2014 – 15. Local FM stations will also be utilized to air important messages to the public. NHM Spots can be finalized for a set time period and the bills paid on a monthly or quarterly basis.

Existing District and Block Level IEC Personnel: Important IEC personnel such as District Health Education Officers (DHEO), Block Health Education Officers (BHEO) and Taluk Health Education Officers (THEO) are the pillars of the IEC programme implementation and will also be trainers for the to be recruited posts of Health Educators to support IEC efforts in the 8 HPDs in Karnataka. At the PHC and Sub-Center level, IEC efforts will be undertaken by the IEC staff along with Sub-centre ANMs and jurisdictional ASHAs. Monitoring will be undertaken by the DHEO or BHEO concerned and Reports are documented and submitted to the block – district and state level.

New channels of IEC/BCC implementation such as the Internet and Mobile networks will also be harnessed in 2014-15 to improve reach and delivery of IEC/BCC messages to the general public. ASHA workers will need to be supported by easy to carry material and preferably mobile based material/information too.

1. Situation Analysis

Karnataka is privileged to have an established primary health care system and 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 Centres was conceived by the Government of India, the State had already made a beginning in establishing a number of PHUs (Primary Health Units) for providing comprehensive Health Care and a delivery system consisting of curative, preventive, Promotive and rehabilitation health care, to the people of the state.

The Karnataka State Integrated Health Policy approved by the State Cabinet on January 31, 2004 underlines the State's long-term vision for the health sector in providing quality health care with equity and responsive to the needs of the people and is guided by the principles of transparency, accountability and community participation.

For NHM, Karnataka followed the pattern of high focus states for programme management units and up gradation of sub-centres (SCs), primary health centres (PHCs) and community health centres (CHCs) through integrated financial envelope. The key features of the implementation of NHM in Karnataka include making the public health delivery system fully functional and accountable to the community, working in a 'mission mode', decentralized planning, delegation of powers, human resource management, community involvement, rigorous monitoring and evaluation against standards, convergence of health related programmes and flexible financing.

Despite impressive economic achievements and health sector reforms, Karnataka faces challenges in its progress towards health related Millennium Development Goals (MDGs). The Infant Mortality Rate (41) and Maternal Mortality Rate (178) as per SRS 2009 remain a matter of concern in the state. Nearly half of all children below five years of age and more than half of women in the reproductive age group are undernourished. Average health indicators for the state mask large inequalities between geographical areas and population groups with significant disparities between the underserved tribal hamlets and the more prosperous areas.

The Government of Karnataka is committed to achieve a sustainable improvement in the health status of all sections of its people, especially women, children and vulnerable group of population such as Schedule Castes and the Schedule Tribes. In addition to the measures for reforms and quality assurance adopted by the Government of Karnataka, it is critical to work simultaneously on the demand generation and influencing social norms and behaviours related to health and its determinants.

Social & Behaviour Change Communication (SBCC) is considered a critical input to meeting the objectives of National Flagship Programmes and the Millennium Development Goals through its focus on influencing, changing and developing human behaviours and social norms. It also provides a key strategy in reaching out to excluded groups and ensuring their participation in government-sponsored programs. Historically, this area of development programming has suffered from a lack of a theoretically-sound, systematic, and evidence-based approach to communication planning, implementation and monitoring. Communication, promotion of services / social marketing, demand generation, and interpersonal communication skills of front line workers remain a weak link that impact on the effectiveness of flagship programmes and other development schemes.

Social and Behaviour Change is a transformation process. Most of the current health communication occurs through what is traditionally known as Information, Education and Communication (IEC) activities; many of which are ad-hoc, disparate and do not make a coherent whole. Therefore, there is a need to have a coherent and strategic system of communication that could serve as an umbrella or bind all the disparate activities and outcomes together and at the same time be a strong motivator for change and influence the age-old social norms.

2. IEC/BCC INFRASTRUCTURE AND HR AVAILABLE IN THE STATE:

STATUS OF HUMAN RESOURCES FROM THE IEC CADRE as of 2013				
POSITION	SANCTIONED POSTS		IN POSITION	VACANT
State level	Regular	Contract (NHM)		
JD (IEC)	1	0	1	0
DD (IEC)	2	0	0	2
Field Publicity Officer	1	0	0	1
Health Education Officer	1	0	0	1
Dy. Health Education Officer	1	0	1	0
Senior Projectionist	1	0	1	0
Second Division Clerk	1	0	1	0
PA to JD (IEC)	1	0	1	0
Carpenter	1	0	1	0
Group D	5	0	2	3
IEC Consultants	0	1	0	1
District Level				
District Health Education Officer (DHEO)	29		17	12
Deputy District Health Education Officer (DyHEO)	71		38	33
Block Health Education Officer	528		326	202
Projectionist	17	0	17	0
Data Entry Operator	0	30	30	0

There is a huge vacancy in IEC cell at state and district levels, hence it is proposed in 2014-15 PIP to fill some key posts like block health education officers at taluka level (2 per taluk) especially in HPDs to communicate with the grass root level.

3. Key Gaps in BCC

The state has covered some ground in the achievement of NHM goals. However, there is a need for accelerated efforts to meet the NHM targets as well as MDGs, without compromising on the quality of services. Further, nutrition and sanitation – which are the two critical determinants of health, also need urgent attention. There is also a need for a long term effort to influence the social norms around gender and caste exclusions and inequities – which of course will require concerted and convergent inter-departmental efforts as well as advocacy and social movement by all stakeholders, civil societies, religious groups, academics and media.

A few innovative IEC/BCC activities planned for 2014-15:

1. Easy to carry IPC tools for Front Line Health Workers will be designed, especially on RMNCH+A.
2. Attempt will be made to devise mobile based application for health workers
3. Social and Web Media such as Facebook and Twitter can also be harnessed for IEC reach

4. Corporate entities will be contacted to find if engagements can be made through CSR
5. Organizing 'TeleMatch' among community members at the community level to propagate healthy habits and healthy behaviour. For example, a tele-match can be organized between community members where an ultraviolet torch is used to identify micro-organisms on the participant's hands and similarly after an intervention such as 'washing hands' to inculcate healthy habits and behaviours. (This will be conducted in priority districts of RMNCH+A which is a novel way of propagating developing skills of SBAs, ANMs & SNs)
6. For posters that are being developed as part of different programme campaigns, it is proposed to insert a calendar at one end of the poster so that it becomes a valued possession and has a longer display life in our health centres.

Key Thematic Areas and Key Messages

Theme	Issue
Adolescent Health & Nutrition	1. Adolescent nutrition
	2. Menstrual hygiene among
	3. Age at marriage
Maternal Health & Nutrition	4. Age at first pregnancy
	5. Spacing between children
	6. Permanent methods for family planning
	7. Early registration of pregnancy
	8. Complete ANC (4 check ups, IFA supplementation, TT vaccination, nutrition & care during pregnancy)
	9. Birth planning / preparedness
	10. Timely identification of and referral for cases with danger signs during pregnancy
	11. Maternal nutrition
	12. Institutional delivery
	13. Post natal care – mother
Child Health & Nutrition	14. Post natal care - new born : Early initiation and exclusive breastfeeding
	15. Post natal care - new born : Thermal care
	16. Post natal care - new born : Infection prevention
	17. Post natal care - new born : Timely identification of and referral for cases with danger signs
	18. Immunization
	19. Complementary feeding
	20. Growth monitoring
Cross Cutting Issues	21. Management of ARI and diarrhea
	22. Gender sensitization
	23. Sanitation and hygiene
	24. Maternal and Infant Death Review
	25. Strengthening Capacity and Referral system

Region Wise Priorities Based on Available Survey Data and District-wise Mapping

Based on a district wise mapping exercise conducted with the DHEOs, Dy. HEOs, IEC Wing and Programme Officers at NHM in 2013, a set of priority issues were identified for each district that require SBCC focus. These priorities have been further substantiated by the findings in the CES 2009, SRS 2012, DLHS-3 and NFHS-3 for Karnataka.

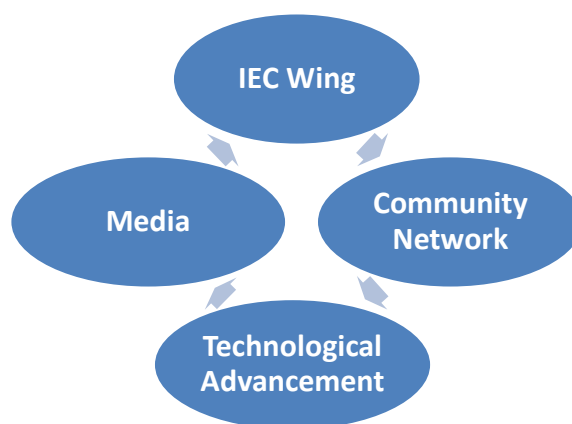
These priorities suggest the need to focus on these thematic issues to make a difference in any of the Programme Areas – Child Health, Maternal Health, Communicable Diseases, Non-communicable diseases, ARSH, Family Planning and PCPNDT which can impact the IMR, MMR and other health indicators.

THEME / PROGRAMME AREA	ISSUE TO BE ADDRESSED BY SBCC	PRIORITY FOR (NO. OF DISTRICTS)	IMPACT INDICATOR	SECONDARY DATA FOR KARNATAKA (COVERAGE EVALUATION SURVEY 2009, DLHS-3 & NFHS -3)
ARSH	Nutrition and healthy life style (adolescent anaemia etc.)	20	MMR	% of anaemic women 42.4%
ARSH	Personal and menstrual hygiene	30	MMR	Use of sanitary napkins – less than 30%
MATERNAL HEALTH	Age at marriage	10	MMR	Marriage below 18 years : 28.5% in rural areas 50.1% in urban areas
MATERNAL HEALTH	Complete ANC, high risk pregnancy identification, referral, follow up	19	MMR	Full ANC coverage 40.2%
MATERNAL HEALTH	Institutional delivery	20	MMR	Institutional delivery 86.4%
MATERNAL HEALTH	Spacing between children	10	MMR	Use of spacing methods 63.6%
FAMILY PLANNING)	Temporary methods of family planning for spacing between children	20	IMR / MMR	Contraception use (any method – female) 63.6% Condom usage 1.7%
CHILD HEALTH	Promote colostrum's feeding, early initiation and exclusive breastfeeding	23	IMR	Early initiation of breastfeeding 38.2%
CHILD HEALTH	New Born Care – delaying the bath, Kangaroo care, hygiene for infection prevention, danger signs	9	IMR	Knowledge about danger signs related to new borns 25%
CHILD HEALTH	Full and timely immunization compliance (with drop outs)	25	IMR	Fully immunized children 78.0%
PCPNDT	Save the girl child (including gender discrimination)	28	MMR	Ultrasound scan for pregnancy 65.9% (urban) 37.9% (rural)
COMMUNICABLE DISEASES	Dengue, Malaria, Chikungunya based on prevalence in the district	18		
COMMUNICABLE DISEASES	Sanitation and hygiene	19		Population without toilets access 69.5%
COMMUNICABLE DISEASES	Health emergency due to disease outbreak (eg. H1N1)			
NON-COMMUNICABLE DISEASES	Importance of healthy life style to manage / prevent Diabetes, Hypertension, cancers and other diseases	19		Obesity 15.3% (women) and 10.9% (men) Tobacco use 45% (men) and 5% (women) Alcohol 28.3% (men) and 1.2% (women)

Environment and Opportunities for SBCC

The SBCC for health promotion in Karnataka can gain from the following primary opportunities:

- (1) **IEC Wing** : an institutional mechanism for overall management of integrated SBCC for health outcomes;
- (2) **Community Network** : SHGs, PRIs and other community networks for social mobilization;
- (3) **Technological Advancement** : facilities like SATCOM for trainings of and review with frontline workers
- (4) **Media** : access of satellite TV as well as mobile phones to communities



IEC Wing for Institutional Mechanism:

The IEC Wing within the department is an institutional mechanism for integrated IEC for all the verticals / sections at the state level. IEC Wing was created through a Government Order in April 2010, with the following objectives

1. Integration of IEC activities of all the National Health Programmes, NHM, KHSDRP and State Health Initiatives.
2. Dissemination of information on the Health Programmes and Government initiatives to the masses.
3. Educating the masses in preventive and promotive health care, hygiene and sanitation.
4. Capacity building and sensitisation of the department personnel, and others involved in health care services of the department.
5. Supporting advancement in health care services through field research.
6. Establishing effective inter-departmental and intra-departmental co-ordination
7. Liaison between the department and the community.

The Wing is headed by a Joint Director and has the following Cells to streamline the IEC activities:

1. Information & Publication Cell
2. Field Research Cell
3. Monitoring & Evaluation Cell
4. Communication & Publicity Cell
5. Programme & Capacity Building Cell
6. Administration Cell

I. Information & Publication Cell

- Publication of health bulletins, manuals, reference guides for department verticals.
- Publication of HFWS monthly news bulletin "Kutumba"
- Development, printing and distribution of publicity material.
- Collection, dissemination of information on the latest developments in Public Health Care
- Compilation of information released by WHO and other World Health Agencies.
- Establishment and maintenance of a Central Health Library.
- Subscription and maintenance of e-journals.
- Collection of information on the Public Health initiatives of other states and other parts of the world.

II. Field Research Cell

- Conducting formative research for providing input to planning process.
- Conducting field statistical research.
- Facilitating field research during times of out breaks etc.
- Providing data (not available with Information Cell), at short notice to enable planning.
- Liaison with health wings of ULBs.

III. Monitoring & Evaluation Cell

- Monitoring of IEC activities in the districts.
- Impact analysis of IEC initiatives at state level and district level in liaison with Field Research Cell.
- Content evaluation of IEC materials

IV. Communication & Publicity Cell

- Liaison with Mass-media for publicity of health programmes.
- Development of visual media publicity material.
- Publicity campaigns
- Facilitation of Health Campaigns

V. Programme & Capacity Building Cell

- Event Management for celebration of important days etc.
- Conduct of mass awareness programmes
- Capacity Building and sensitization activities for the department personnel, sourced health workers and other peripheral workers in the health care service delivery system.
- Conduct of counselling programmes for target population.
- Participating in public programmes/exhibitions conducted by other Governmental Agencies.

All the Consultants posts in the above cells are vacant.

The cadres of District Health Education Officers (DHEO) and Block Health Education Officer (BHEO) are mandated to manage the SBCC functions at the district, block and village level. However, there are capacity gaps in terms of large number of vacancies of these cadres, outdated job descriptions as well as inadequate skills given the required shift management of SBCC (i.e. from one of dissemination of messages as in typical IEC aiming at raising awareness to a more participatory process aiming at influencing behaviors & norms through dialogue & engagement of stakeholders in the SBCC process). Hence, the IEC/BCC Strengthening process should take into account these needs and address them.

Prioritizing Behaviours

The RMNCH+A issues identified for SBCC interventions are listed in the previous sections of this document. The issues are classified into three categories:

1. **Gateway behaviors:** which will lead the continuum of communication and change to other behaviors as well? For example, early registration of pregnancy can be Gateway behaviour to ANC and birth planning / preparedness and institutional delivery related behaviors. Similarly, institutional delivery can be another Gateway behaviour for breastfeeding, thermal care of the new born.
2. **Quick Wins behaviours:** which are low hanging fruits with high, often multiple impact and therefore, must be prioritized.
3. **Long Term behaviours:** which are more complex, sometimes normative and require sustained, long term efforts

The rationale for categorization is drawn from:

- Evidence of association of the behaviors to prevent outcomes such as maternal mortality, neonatal and child mortality, anemia

Magnitude of the behavioral problem and potential for change through BCC approaches

Theme	Issue / Behaviour	Classification
Adolescent Health & Nutrition	Adolescent nutrition	Long term
	Menstrual hygiene among	Long term
	Age at marriage	Long term
Maternal Health & Nutrition	Age at first pregnancy	Long term
	Spacing between children	Long term
	Early registration of pregnancy	Gateway
	Complete ANC (4 check-ups, IFA supplementation, TT vaccination, nutrition & care during pregnancy)	Quick win
	Timely identification of and referral for cases with danger signs during pregnancy	Quick win
	Institutional delivery	Gateway
Child Health & Nutrition	10) Post natal care - new born : Early initiation and exclusive breastfeeding	Quick win

	11) Post natal care - new born : Thermal care	Quick win
	12) Post natal care - new born : Infection prevention	Quick win
	13) Post natal care - new born : Timely identification of and referral for cases with danger signs	Quick win
	14) Immunization	Long term
Cross Cutting Issues	15) Gender sensitization	Long term
	16) Sanitation and hygiene	Quick win

NHM will focus on the Gateway and Quick-wins behaviours on priority through strategic and intensive SBCC interventions using a combination of IPC, social mobilization, advocacy approaches supplemented with the use of mass media, outdoor media, mid media, SBCC materials and tools. These should be closely monitored and measured against a baseline overtime (A baseline research will also be undertaken to fill this void)

Timelines for SBCC Implementation

Activity / Task	2014							2015
Planning for SBCC breastfeeding promotion Printing of SBCC materials & duplication of IPC videos and supply to districts Guidelines to DMHOs and DHEOs through SATCOM. Orientation of THEOs & BHEOs for planning & monitoring of activities - through SATCOM. Orientation of and planning with ASHA for SBCC activities by THEOs & BHEOs								
Implementation of SBCC activities for breastfeeding promotion House hold visits by ASHA as per the audience groups for IPCDiscussion in the SHG meetings Screening of IPC video and facilitated discussion with the audience groupsCounseling during VHNDMeeting with village level influencers Display and distribution of SBCC materials								
Briefing on to DMHOs and DHEOs - through SATCOM								
Orientation of THEOs and BHEOs for planning & monitoring of activities - through SATCOM								
District level planning meeting								
Printing and dissemination of thematic SBCC materials – duly pre-tested in the field								
Duplication and dissemination of thematic IPC films								
Getting the training module and IPC tools ready								
Identifying the block level trainers and master trainers								
Conducting the ToTs – state and district level								
Conducting the IPC & SBCC skill building of frontline workers (ASHAs)								
Developing M&E systems (framework, tools)								
Hygiene & Sanitation for infection prevention (ARI & Diarrhoea)								
Thermal care for new born care								
Timely identification of and referral for new borns with danger signs								
Early registration of pregnancy								
Complete ANC								
Danger signs during pregnancy								
Institutional delivery								

Adolescent nutrition								
Adolescent – menstrual & general hygiene								
Other issues (age at marriage, gender, promotion of schemes etc)								
Hygiene & sanitation								

AUDIENCE SEGMENTATION FOR INDIVIDUAL BEHAVIOURS & COMMUNICATION STRATEGY

Gateway Behaviour: Early registration with ANM / AWW within the first trimester i.e. 12 weeks of pregnancy

Communication Objectives:

1. Percentage of newly married women in Karnataka who know that child birth is registration of pregnancy must be done within the first 12 weeks increases from X% to Y% by March 2015(**Knowledge related objective**)
2. Percentage of newly married women in Karnataka who can state at least two benefits of early registration increases from X% to Y% by March 2015(**Knowledge related objective**)
3. Percentage of newly married women in Karnataka who stated the intention to register within 12 weeks of pregnancy increases from X% to Y% by March 2015(**Attitude related objective**)
4. Percentage of newly married women in Karnataka who registered within 12 weeks of pregnancy increases from X% to Y% by March 2015(**Practice related objective**)

Current Behaviour	Desired Behavior	Barrier	Primary Stakeholder / Audience	Secondary Stakeholder / Audience	Key Message	Approach / Media / Channels
The registration for pregnancy is delayed	Women should register pregnancy within the first 12 weeks	The culture to hide the news about pregnancy from others ASHA does not always counsel the newly married women about confirmation of pregnancy and its early registration	New married women Women having one child	Husbands Mothers in law ASHA & ANM	Registration of pregnancy within 12 weeks Benefits of early registration	House hold level IPC by ASHA with primary & secondary audiences IPC video in group setting by ASHA with primary audiences Discussion in SHG meeting Poster display / leaflet dissemination IPC skills training for ASHA

Gateway Behaviour: Pregnant women choose health facility for delivery of child birth

Communication Objectives:

1. Percentage of pregnant women in their last trimester in Karnataka who know that the child birth should happen in health facility increases from X% to Y% by March 2015(**Knowledge related objective**)

2. Percentage of pregnant women in their last trimester in Karnataka who can state at least one benefit of institutional delivery increases from X% to Y% by March 2015(**Knowledge related objective**)
3. Percentage of pregnant women in their last trimester in Karnataka who can state the health facility where they will go for child birth increases from X% to Y% by March 2015 increases from X% to Y% by March 2015(**Attitude related objective**)
4. Percentage of women with children below 2 years in Karnataka who had the child birth in health facility increases from X% to Y% by March 2015(**Practice related objective**)

Current Behaviour	Desired Behavior	Barrier	Primary Stakeholder / Audience	Secondary Stakeholder / Audience	Key Message	Approach / Media Channels
Child birth taking place at home in unsafe and unsupervised conditions	Child birth happens in health facilities under supervision by trained health service provider	Unawareness among women that every delivery has the risk of mortality. Deliveries at home are considered to be safe. ASHA does not always counsel the pregnant women about benefits of institutional delivery	Women in their last trimester of pregnancy	Husbands Mothers in law ASHA & ANM	Benefits of institutional delivery Risk associated with deliveries Risk of delivering the child at home Entitlements under JSY	House hold level IPC by ASHA with primary & secondary audiences IPC video in group setting by ASHA with primary audiences Discussion in SHG meeting Poster display / leaflet dissemination IPC skills training for ASHA

Quick-wins: Pregnant women avail complete ANC (4 check-ups, IFA supplementation, TT vaccination, nutrition & care during pregnancy)

Communication Objectives:

1. Percentage of pregnant women in Karnataka who can state the four major components of ANC increases from X% to Y% by March 2015(**Knowledge related objective**)
2. Percentage of pregnant women in Karnataka who can state the entitlements for pregnant women under ICDS and JSY increases from X% to Y% by March 2015(**Knowledge related objective**)
3. Percentage of pregnant women in Karnataka who reported of having consumed 100 IFA tablets increases from X% to Y% by March 2015 increases from X% to Y% by March 2015(**Practice related objective**)
4. Percentage of pregnant women in Karnataka who received full ANC check-ups including Blood + Urine test, BP measurement and head to toe examination increases from X% to Y% by March 2015 increases from X% to Y% by March 2015(**Practice related objective**)

Current Behavior	Desire Behavior	Barrier	Barrier	Primary Stakeholder / Audience	Secondary Stakeholder / Audience	Key Message	Approach / Media / Channels
The full ANC package is not availed by pregnant women	Pregnant Women should complete ANC checkups at the health facility	Lack of awareness among the women about the ANC package and its constituents. Lack of knowledge about the importance of availing ANC checkups for the health of the mother and child.	Lack of awareness about the ANC package and its importance; lack of knowledge about care and nutrition requirements during pregnancy	Women who are currently pregnant Women who are newly married	Husbands Mothers in law ASHA & ANM	Completing the 4 ANC checkups mandatorily Benefits of availing the ANC package	Household level IPC by ASHA with primary & secondary audiences IPC video in group setting by ASHA with primary audiences Discussion in SHG meeting Poster display / leaflet dissemination IPC skills training for ASHA
		ASHA does not always counsel the pregnant women about the benefits of ANC and completing 4 checkups.					

Quick-wins: Timely identification of and referral for cases with danger signs during pregnancy

Communication Objectives:

Percentage of pregnant women in Karnataka who know the symptoms of high risk pregnancy or danger signs increases from X% to Y% by March 2015(**Knowledge related objective**)

Percentage of pregnant women in Karnataka who can state the danger signs of pregnancy and are aware of where to go and whom to contact when these signs appear from X% to Y% by March 2015(**Knowledge related objective**)

Percentage of pregnant women in Karnataka who reported having recognized early danger signs during pregnancy increases from X% to Y% by March 2015 increases from X% to Y% by March 2015(**Practice related objective**)

Percentage of pregnant women in Karnataka who were able to identify and reach the health facility with health system support when symptoms surface increases

from X% to Y% by March 2014 increases from X% to Y% by March 2014
(Practice related objective)

Current Behaviour	Desired Behaviour	Barrier	Primary Stakeholder / Audience	Secondary Stakeholder / Audience	Key Message	Approach / Media / Channels
Inability to identify the danger signs during pregnancy and lack of awareness of what to do when such danger signs are recognized	Women are able to identify danger signs during pregnancy through health system support and are able to reach a health facility when such symptoms arise.	Lack of awareness that danger signs during pregnancy should be recognized and attended to immediately. Lack of awareness that mobility support is being offered through 108 service for such eventualities. ASHA does not always counsel the pregnant women about benefits early identification of danger signs and about 108 service	Pregnant women	Husbands Mothers in law ASHA & ANM	Benefits of identifying unusual symptoms during pregnancy Risk associated with danger signs during pregnancy Risk of not recognizing these symptoms early and not presenting to the nearest health facility Entitlements under 108 scheme	House hold level IPC by ASHA with primary & secondary audiences IPC video in group setting by ASHA with primary audiences Discussion in SHG meeting Poster display / leaflet dissemination IPC skills training for ASHA

Quick-wins: Post Natal Care - new born : Early initiation and exclusive breastfeeding

Communication Objectives:

Percentage of pregnant women in Karnataka who breast-feed colostrum to their newborns increases from X% to Y% by March 2015(**Knowledge related objective**)

Percentage of pregnant women in Karnataka who give no pre-lacteal feeds to the newborn increases from X% to Y% by March 2015(**Knowledge related objective**)

Percentage of pregnant women in Karnataka who realize the importance of breast-feeding the newborn increases from X% to Y% by March 2015 increases from X% to Y% by March 2015(**Practice related objective**)

Percentage of pregnant women in Karnataka who breast-feed the newborn exclusively for a period of 6 months increases from X% to Y% by March 2015 increases from X% to Y% by March 2015(**Practice related objective**)

Current Behaviour	Desired Behavior	Barrier	Primary Stakeholder / Audience	Secondary Stakeholder / Audience	Key Message	Approach / Media / Channels
Not feeding colostrum to the newborn. Engaging in prelacteal feeds and not exclusively breast-feeding the newborn for a period of 6 months	Women who recognize the value of feeding colostrum to the newborn baby. Women who breast-feed the baby exclusively for a period of 6 months.	Cultural practices that promote colostrum discarding. Lack of awareness regarding the importance of colostrum to the baby. Lack of awareness regarding exclusive breast-feeding. ASHA does not always counsel the pregnant women about benefits of exclusive breast-feeding	Pregnant women Women who are newly married	Husbands Mothers in law ASHA & ANM	Benefits of breast-feeding, especially early initiation and colostrum feeding Risk of not breast-feeding to the newborn Importance of exclusive breast-feeding to the baby	House hold level IPC by ASHA with primary & secondary audiences IPC video in group setting by ASHA with primary audiences Discussion in SHG meeting Poster display / leaflet dissemination IPC skills training for ASHA

Quick-wins: Post Natal Care – Thermal Care and Infection Control

Communication Objectives:

Percentage of pregnant women in Karnataka who do not bathe their newborns for one week increases from X% to Y% by March 2015(**Knowledge related objective**)

Percentage of pregnant women in Karnataka who give skin to skin thermal care to the newborn increases from X% to Y% by March 2015(**Knowledge related objective**)

Percentage of pregnant women in Karnataka who keep the cord stump dry and prevent infection increases from X% to Y% by March 2015 increases from X% to Y% by March 2015(**Practice related objective**)

Percentage of pregnant women in Karnataka who recognize danger signs and take immediate action increases from X% to Y% by March 2015 increases from X% to Y% by March 2015(**Practice related objective**)

Current Behaviour	Desired Behavior	Barrier	Primary Stakeholder / Audience	Secondary Stakeholder / Audience	Key Message	Approach / Media / Channels
Bathing the newborn as soon as it is born or within a day or two. Not providing skin to skin thermal care to the newborn. Not keeping the cord stump dry till it falls off. Not recognizing danger signs and taking immediate action	Women who recognize the value of not bathing a child before 1 week of birth. Women who practice skin to skin thermal care for the newborn and keep the cord stump dry. Mothers who recognize the danger signs of pneumonia and take the child to the health provider	Cultural practices that promote the baby within a day. Lack of awareness regarding the importance of skin to skin thermal care for the newborn. Lack of awareness regarding keeping the cord stump dry and open. ASHA does not always counsel the pregnant women about benefits thermal care, hygiene of cord stump and danger signs in the newborn	Pregnant women Women who are newly married	Husbands Mothers in law ASHA & ANM	Benefits of delaying giving a bath to the newborn to be put forth Risk of not providing skin to skin thermal care to the newborn Importance of keeping the cord stump clean and dry to avoid infection.	House hold level IPC by ASHA with primary & secondary audiences IPC video in group setting by ASHA with primary audiences Discussion in SHG meeting Poster display / leaflet dissemination IPC skills training for ASHA

Quick-wins: Post Natal Care - new born : Timely identification of and referral for cases and danger signs

Communication Objectives:

Percentage of pregnant women in Karnataka who recognize danger signs in the newborn increases from X% to Y% by March 2015(**Knowledge related objective**)

Percentage of pregnant women in Karnataka who recognize signs of breathing difficulty in the newborn increases from X% to Y% by March 2015(**Knowledge related objective**)

Percentage of pregnant women in Karnataka who keep the baby warm and prevent cord stump infection increases from X% to Y% by March 2015 increases from X% to Y% by March 2015(**Practice related objective**)

Percentage of pregnant women in Karnataka who take the child to the health provider in the event of recognition of danger signs increases from X% to Y% by March 2015 increases from X% to Y% by March 2015(**Practice related objective**)

Current Behaviour	Desired Behavior	Barrier	Primary Stakeholder / Audience	Secondary Stakeholder / Audience	Key Message	Approach / Media / Channels
Bathing the newborn as soon as it is born or within a day or two. Not providing skin to skin thermal care to the newborn. Not keeping the cord stump dry till it falls off. Not recognizing danger signs and taking immediate action.	Women who recognise the danger signs in the newborn such as breathing difficulty, rapid respiration, etc. Women who recognize that the cord stump should be kept clean and dry for it to heal and prevent infection.	Lack of awareness regarding what are danger signs in the newborn. Lack of awareness about the need to maintain the cord stump clean and dry. Lack of awareness about recognizing danger signs and taking timely medical assistance. ASHA does not always counsel the pregnant women about benefits of thermal care, hygiene of cord stump, general hygiene and danger signs in the newborn	Pregnant women Women who are newly married	Husbands Mothers in law ASHA & ANM	Benefits of delaying giving a bath to the newborn to be reinforced Importance of keeping the cord stump clean and dry to avoid infection. Benefits of maintaining hygiene while handling the child and need to recognize danger signs early and taken appropriate action by visiting a health provider	House hold level IPC by ASHA with primary & secondary audiences IPC video in group setting by ASHA with primary audiences Discussion in SHG meeting Poster display / leaflet dissemination IPC skills training for ASHA

Thus, once the Gateway Behaviours and the Quick Wins are targeted, the Long Term Behaviours which are more complex, sometimes normative and require sustained, long term efforts need to be focused upon. The long term behaviours which need to be targeted include those surrounding:

1. Adolescent Nutrition
2. Menstrual hygiene among adolescents
3. Age at Marriage
4. Age at First Pregnancy
5. Spacing between Children
6. Immunization Compliance &
7. Gender Sensitization

These are more normative and hence require more time to influence and change. Concerted and regular efforts need to be put in to make sure these can be modified. The recommendation is that health department / NRHM should focus on the Gateway and Quick-wins behaviours on priority through strategic and intensive SBCC interventions using a combination of IPC, social mobilization, advocacy approaches supplemented with the use of mass media, outdoor media, mid media, SBCC materials and tools. These should be closely monitored and measured against a baseline over time.

2. PLAN FOR MONITORING AND EVALUATION:

Plan for monitoring and evaluation of communication activities which needs to include the key BCC indicators to be used for assessing the outcomes envisaged.

Monitoring BCC Inputs in Mass Media

Mass media includes electronic and print media. Electronic media includes TV, Radio, Cable and Mobile Phone while the Print Media includes newspapers, periodicals and magazines. The number of persons viewing or listening to a programme provides insights on programme exposure. These can be further segmented by audience. Monitoring of electronic media will entail tracking if TV and Radio spots were aired as planned. Mass media channels often air TV spots meant for semi-literate audiences to the urban literate audiences in cities. Therefore, there is a need to develop a separate system for tracking appropriateness of electronic media.

Print media such as pamphlets and handbills are important at sub-district and community levels. Often print materials are received at district headquarters and remain unused for months altogether without being despatched to peripheral centres. It is important therefore to monitor the distribution of materials from the district to the village level.

Monitoring at the Community and Household Level

At the community level, monitoring mainly involves keeping a track of the number of say group meetings planned versus those conducted and the people who actually participated versus the expected number of people. Another reliable method is to conduct a pre-test and post-test survey of people assembled at any community meeting or group discussion to make sure that pre-meeting knowledge is ascertained and post-meeting awareness could be captured.

Monthly monitoring data can be utilized to monitor trends in household behaviours. For example, use of spacing methods among eligible women, or first trimester registrations among pregnant women. However, for diet, hygiene and treatment seeking behaviours it is difficult to monitor on a monthly basis. These health behaviours have to be monitored or evaluated at longer intervals through evaluation surveys

3. TRAINING PLAN FOR IEC/BCC:

A training plan for IEC/BCC is being prepared and the requirements of training for all IEC cadres are being planned.

A Cascade Model of Training to be planned and implemented through the nodal institute for training under the DHFWS, namely the State Institute of Health and Family Welfare (SIHFW).

The SIHFW is envisaged to take up full responsibility regarding health manpower resource development beginning from induction trainings to all health professionals before they join their respective duties or during the course of their service both at the district as well as State level as is currently being done in a splendid fashion. The curriculum and training methodology needs to incorporate certain components of improving Inter Personal Communication and effectuating Social and Behavioural Change Communication on the ground.

Steps to be taken up for enhancing IEC preparedness and meet training needs of the IEC cadre:

1. Preparing a Training Strategy for the IEC cadre and ancillary grass-root workers in the health area – namely the ASHA worker and the Anganwadi worker across entire Karnataka under the NRHM
2. Develop a Training Calendar in consultation with Women and Child Welfare Department (WCD) and Health Department, possibly Education Department and other stakeholders
3. Developing Training specific guidelines
4. Conduct State Level and District Level Training of Trainers (ToT) workshops
5. Develop Training Specific Learning Material/ background material

These trainings will essentially focus on:

1. Improving Interpersonal Skills – Soft skills up gradation- motivation, teamwork, leadership, counselling
2. Technical skill up gradation in terms of maternal health, child health, public health, disease control etc.
3. Up gradation of various dimensions of BCC skills that are required and
4. Preparation and interpretation of various health action plans including implementation, monitoring and evaluation, tracking outcomes, etc.

1. ASHAs (Accredited Social Health Activities) and Anganwadi Workers (AWWs) as IEC foot soldiers:

There are nearly 30,000 ASHAs in Karnataka and they represent a big human resource for SBCC. The key areas of work for the ASHAs along the continuum of communication are IPC at the household level which includes mothers and other household members. It is necessary to set norms for the ASHA home visits. And her capacity to address the specific MCH needs of each eligible household can be developed. Her role vis-a- vis group meetings is to mobilize the appropriate audience for the ANMs group meetings and for VHND. She should give a special focus to ST and other vulnerable groups.

Skills Required to be reinforced for ASHAs and Anganwadi Workers:

1. Persuasion skills
2. Needs assessment of the household; Listening skills needed to identify household specific behavioural needs
3. Conceptual skills required to link provision of IPC at household level to specific behavioural change
4. Two-way communication skills required on how to conduct effective home visits
5. Identify relevant audience/s

2. ANMs

Karnataka has about 8,500 ANMs. They can provide SBCC along with other maternal and child health services. Their main areas of work along the continuum of communication are household level IPC, group meetings for women, school health for children and use of ICT. Some mechanisms to motivate the ANM to work better can be appreciation from the medical officers, appreciation awards from both the community and the health system. Community level awards can include felicitation at VHND. The ANMs need to build their capacity for the following SBCC skills:

1. Persuasion skills required for motivating women for quality ANC checkups, consumption of IFA tablets, etc.
2. For assessing the needs of the pregnant woman and mothers of children under three years
3. Conceptual skills required to link conducting IPC and group sessions to specific behavioural outcomes

4. Two way communication skills required on how to conduct effective IPC and group sessions
5. Skills for providing supportive supervision for ASHA's SBCC work; for ensuring that the appropriate audience has been selected
6. Needs to identify specific appropriate audiences (non-users, high risk, vulnerable groups etc.)

A similar training pattern like the ASHA's is proposed for the ANMs. Here too, BHEOs will be trained as trainers. The Health Educators have a vital role in ensuring the implementation of effective SBCC strategies. In addition they are crucial for local level advocacy with Panchayat members, SHG groups and informal local leaders. Their other important tasks include preparation of a monthly plan of action for the PHC, planning specific SBCC theme based activities for VHND. They also can plan use of PHC space and facilities to promote BCC.

Role of Regional Training Centres (RTCs) and District Training Institutions (DTCs):

The 4 Regional Training Centres catering to the 4 divisions of Karnataka will be responsible for training of Health Educators, ASHA workers, Anganwadi workers along with their normal duties of training all cadres as per the guidelines issued by the Government.

Further, the 19 District Training Centres (DTCs) across most districts of Karnataka will aid in carrying out cascade training of grassroot functionaries at the district level.

BUDGET 2014-15

B 10.1 : Strengthening of BCC/IEC Bureaus at District level

(Rs. In lakhs)

FMR Code	Activity Proposed/ Name of the Activity Description	Whether New/Being Continued	Achievements if continued from previous years	Justification	Deliverables	Funding proposed	Remarks
B-10.1.1	Hiring of Data Entry Operators	Being Continued	All districts have utilized the services of data entry operators	The post of data entry operator is necessary at the district level for compilation of data from all the primary health centres of the districts of IEC and health programme & after compilation sending the reports to the division & the state level at regular intervals	Collection & Compilation of IEC & others reports & sending the same to the state level	54.00	(Rs. 15,000/- per month for each DEO x 12 months x 30 districts) District Level activity
B-10.1.2	POL/Hiring Charges for IEC section	Being Continued	All districts have utilized the POL charges given to them	DyHEOs and DHEOs need to travel across the district for effective implementation & monitoring of IEC activity in the district and supervise this activity apart from guidance in order to improve the IEC activities effectively in the district. This will enable the supervisee to improve their knowledge & skill in IEC in communication of messages.	: Improvement of knowledge & skill of IEC staff : Improvement of field visits for supervision	36.00	(Rs. 10,000/- per month for each District x 12 months x 30 districts) District Level activity
B-10.1.3	Contingency for IEC section	Being Continued	All districts have utilized the contingency charges given to them	Every district is given Rs.1,000/- per month for contingency expenditure that occur in their district. This will enable the district IEC bureau in improving their performance.	Strengthening of IEC	3.60	(Rs. 1,000/- per month x 12 months x 30 districts) District Level activity
B-10.1.4	Hiring charges for Group 'D'	New activity	-	This is a new activity as the District Health Education Officers requires an assistance in terms of group 'D' for his/her office work including distribution of IEC materials as no group D official is posted to his/her section in the districts.	Strengthening	16.20	(Rs. 9000/- per month x 6 months x 30 districts) District Level activity
B-10.1.5	Recruitment of Block Health Education Officers	New Activity	-	a) The RMNCH+A programme is implemented in Karnataka district on high priority basis in 8 districts namely Bijapur,	Education of target groups to improve	50.40	(Rs. 10,000/- per month x 6 months x

	at the PHC level in 8 high priority RMNCH+A districts on contract basis and training (capacity building) of these newly recruited (contract) BHEOs.			Yadgir, Gadag, Bagalkote, Bellary, Raichur, Gulbarga & Koppal districts. In these districts 453 PHCs are functioning whereas the post of BHEOs sanctioned are 127 & the number of BHEOs working is only 94. leaving a gap of 326 BHEOs who are required for conducting IEC activities in these districts. Hence it proposed recruitment of 2 BHEOs per taluk in 8 HPDs. Totally 84 BHEOs.They will be recruited on contract basis with a monthly salary of Rs. 10,000/-. The minimum qualification will be fixed as a Bachelor of Social Sciences with Sociology as one of the major subjects in their graduation study. The recruitment will be made as per the reservation system.	their health status especially in terms of RMNCH+A programmes in the district		84BHEOs) District Level activity
				b) These newly recruited BHEOs need to be trained under NHM for a period of 6 days at HFWFCs (Induction Training) the cost of the training will be around Rs. 19.56 lakhs (Rs.6,000/- for each candidate x 76 candidates). This enhances their capacity building in better functioning. The Training of trainers will be taken up for 2 days	They will be able to function effectively after the training programme	4.56	(Rs. 6000/- for the training of each candidate approximately x 76 candidates.)

Breakup of different district plans as per the proposed activity

Sl.No	Activity /District plan	Unit cost	Quantity	Total cost (Rs.lakhs)	Details
1	Hiring of Data Entry Operators	Rs. 15,000	15000x12x30 district	54.00	Details of each item are given above
2	POL/Hiring Charges for IEC section	Rs. 10,000	10000x12x30 district	36.00	
3	Contingency for IEC section	Rs. 1,000	1000x12x30 district	3.60	
4	Hiring charges for Group 'D'	Rs. 9,000	9000x6x30 district	16.20	
5	Recruitment of 84Block Health Education Officers at the PHC level in 8 high priority RMNCH+A districts on contract basis and training of these newly recruited (contract) BHEOs for 6 days & training of trainers for 2 days	Rs. 10,000 Rs. 6,000	10000x6x84=50.4 6000x326 =4.56	54.96	
	Subtotal			164.76	

B 10 : Strengthening of BCC/IEC Bureaus at State level
(Rs. In lakhs)

FMR Code	Activity Proposed/ Name of the Activity Description	Whether New/Being Continued	Achievements if continued from previous years	Justification	Deliverables	Funding proposed	Remarks
B-10.1.6	Hiring of Group "D"	New activity	-	For office work.	Strengthening of IEC	0.72	(Rs. 12,000/- x 1 x 6 months) State Level activity
B-10.1.7	State, Division, District level review meetings of IEC staff and IMPCC meeting will also be conducted at the state level	Continued activity	Conducted in previous years	Review meeting help for planning and monitoring of IEC activities at the district level. The IMPCC meeting will help in coordinating with other agencies of different departments. Four divisional meetings, 1 state level meeting of IEC personnel and 1 IMPCC meeting will be conducted at state headquarters.	Evaluation of work with reference to performance in the districts.	3.00	(Rs. 50,000/- per meeting x 6 meetings) State Level activity
B-10.1.8	Contingency for IEC Section:	Continued activity	-	IEC section needs to be highly flexible in attending to the needs of multiple issues which may arise. Hence contingency is planned to meet the unforeseen expenses. Purchase of periodicals, reference books and POL to the vehicle.	Strengthening	5.00	State Level activity
				Total		8.72	

B-10.2.1	BCC/IEC Activities for MH (Rs. In lakhs)						
FMR Code	Activity Proposed/ Name of the Activity Description	Whether New/Being Continued	Achievements if continued from previous years	Justification	Deliverables	Funding proposed	Remarks
B-10.2.1.1	Printing of Educational materials on NHM to support Inter personal communication at field level	New activity	-	For Inter Personal Communication educational aids and also for distribution to community and field staffs are needed. Folders, on JSSK & age at marriage. JSSK folder - Rs. 4 age at marriage and poster at Rs. 5. One lakh folders and One lakh posters.	Messages on MH & CH programmes	9.00	(Rs. 4.00 x one lakh copies =4.00 lakhs Rs. 5.00 x one lakh copies) State Level activity
B-10.2.1.2	Telecasting Of Documentaries/Tel efilms/T.V. spots on NMH and RMNCH+A Schemes. (Production and telecasting in Doordarshan & Private Channels.)	Continued activity	-	Films on story line attract people. Hence, tele-films and documentaries on various MH components and also various schemes like ASHA, Madilu etc. would be made to publicise through Television channels to reach out large number of people at short time. This would also give visibility for NHM. -This activity is being continued but could not be taken up last year due to non- availability of funds	Delivery of messages through telecast. Messages on NHM programmes.	16.00	(1 lakh for documentary 1 lakh for TV spots & 14.00 lakhs for telecasting) State Level activity
B-10.2.1.3	Production & Telecast of Panel discussions/ interviews on Doordarshan	Continued activity	-	Production & Telecast of Panel discussions/ interviews on Doordarshan under NHM. This activity is being continued but could not be taken up last year due to non -availability of	Delivery of messages through telecast. Messages on NHM	4.00	(Rs. 50,000/- per unit x 8 occasions) State Level activity

				funds	programmes.		
B-10.2.1.4	Production & Broadcasting charges of variety health programmes on Akashavani	Continued activity	-	Info-commercials, Interviews, Radio dramas, phone-in programmes will be conducted. -This activity is being continued but could not be taken up last year due to non availability of funds.	Delivery of messages through broadcast. Messages on NHM programmes.	10.00	State Level activity
B-10.2.1.5	Exhibition Panel Boards on NHM Schemes: (Standies)	New activity	-	Exhibition panels attract Masses. Hence NHM Schemes will be Publicised through Exhibition Panels/standies. -20 panels for each district will be given to depict NHM programmes. These will be exhibited wherever exhibitions are conducted in the districts & will be utilized by the districts authority for fresh messages as deemed fit by the districts. And one set will be utilized for the state headquarters.	Panels containing messages	18.60	(Rs. 3000 x 20 x 30 Districts + 1 for state headquarters.) State Level activity
B-10.2.1.6	Printing item of Local issues of the district on Maternal Health and CH.	New activity		This will help in printing item on Local issues of the district on Maternal Health and CH in local language like posters/folders/hand outs, as deemed fit by the districts. This can be utilized for IPC sessions in the concern district. Each taluk in the district will be given an amount of Rs. 10.00 lakhs for this purpose.	Messages on MH & CH programmes like JSSK, RBSK, JSY	17.60	(Rs. 10,000/- per Taluk x 176 taluks) District Level activity
B-10.2.1.7	Press Advertisements at the district level	New activity	-	Press advertisement on various issues of NHM including reduction of IMR & MMR. Can be taken up	Messages on RMNCH+A programme	18.00	(Rs. 60,000/- per district x 30 districts.)

				at the district level depending upon the issues. This is a district level activity.			District Level activity
B-10.2.1.8	District Level Exhibitions, Tableaus on important events	New activity	-	Exhibitions have to be conducted in 8 RMNCH+A priority districts. Each district will be given Rs. 1.00 lakh for conducting the exhibition. Mysore district will be allotted Rs. 5.00 lakhs whereas, Tumkur & Bellary Districts will be allotted Rs.3.00 lakhs each as they have major exhibitions in their districts. Bellary districts will be given an additional of Rs. 1.00 (1+3 lakhs) as it comes under 8 districts.	Messages on RMNCH+A programme	19.00	(8 RMNCH+A districts = 8.00 (1 lakh each) + Mysore district 5.00 lakhs+Tumkur district 3.00 lakhs + Bellary district (additional) 3.00) District Level activity
B-10.2.1.9	Folk media programme @ Rs. 50,000/- per Taluk	New activity	-	Folk Media has a special place among the people and can be used to instil healthy behaviours, bring about behavioural change communication and inform the public about health programmes of the government in the rural areas at as it has a greater attraction. In all 176 Taluks depending upon the issues in each Taluk street plays will be arranged.	Street plays giving messages on RMNCH+A & other programmes of the department	88.00	(Rs.50,000 per taluk (10 programmes for each taluk at the rate of Rs.5000/-) x 176 taluks) District Level activity
		Sl.No	Item	No. / Description			
		1	Folk media format to be used	Street play			
		2	Area to be covered (No. of blocks/villages)	176 taluks x 10 programmes = 1760 programmes.			
		3	Teams available/needed for the activity	3 teams in each district x 30 districts= 90 teams.			

		4	No. of shows possible by a troupe in a day	1 show in a day by one troupe in each area/village		
		5	Beat plan preparation	The action plan will be prepared by the district authority for carrying out this activity as per their needs.		
		6	Monitoring methodology	One of the staff members, especially the Jurisdictional junior health assistants (male and or junior assistants female will be attending the show and it has to be certified by him/her as well as the local ASHA/SHG member/an NGO. The taluk BHEO and the DHEO/DyHEO will be visiting them also during their itinerary as part of their work. The taluk health officials will be requested to monitor/follow up this activity.		

B-10.2.1.10	Divisional level workshop/ training for the folk artists to perform street plays.	New activity	-	Prior to the taking up of the activity of assigning the artist to carry out their activity in the field it is necessary to train them in NHM thematic issues in order to incorporate in their shows. Hence 4 divisional workshops will be organised at 4 divisional places. The professional artists will be involved for the development of model folk street play teams for each division in order to train them so that they can inform the public about health programmes available in every Taluk	Messages on RMNCH+A & other programmes for conducting better street plays in the villages.	14.00	(4 divisional workshops @ rate of Rs. 3.50 lakhs) State Level activity
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				of the State.			
B-10.2.1.11	Awareness programme at Sub-centre level for reducing MMR Rs. 700/-per programme	Continued activity	During the year 2013-14 up to the end of 28 th February the progress of achievement is 71% and the remaining will be covered during march 2014. The achievement in question is due to delay in sanction of funds. (supplementary)	Awareness activity to be conducted at every Sub-Center in Karnataka (8811 sub-centers) plus 30% extra for sub-centers in 8 HPDs (Bagalakote, Bijapur, Gadag, Bellary, Gulbarga, Koppal, Raichur & Yadgiri districts) thus an additional of 551 additional programmes/activities totalling to 9362 programmes where activity is to be conducted. Activity to be conducted by ANM and ASHA with attendance and supervision of BHEO/DyHEO/DHEO and certified reports to be submitted. For this activity printing material wide serial no. 10.2.1.1 and 10.2.1.6 will be utilized as tools. This is a continued activity which helps in creating awareness in the community about problems of maternal health & its prevention especially the pregnant mothers.	This being an IPC session messages on RMNCH+A will be communicate to the group members about prevention & control of maternal infant deaths.	65.54	(Rs. 700/- for each programme x 9362 programmes) District Level activity

Breakup of funds proposed for the proposed activities under MH

Sl.No	Activity /State plan	Unit cost	Quantity	Total cost (Rs.lakhs)	Details
1	Printing of Educational materials on NHM to support Inter personal communication at field level	Rs. 4.00 x one lakh copies (folder) =4.00 lakhs Rs. 5.00 x one lakh copies (poster)	- one lakh copies (folder) - one lakh copies (poster)	9.00	Details of each item are given above
2	Telecasting Of Documentaries/Telefilms/T.V. spots on	-	-	16.00	

	NMH and RMNCH+A Schemes. (Production and telecasting in Doordarshan & Private Channels.)				
3	Production & Telecast of Panel discussions/ interviews on Doordarshan	Rs. 50,000/- per unit x 8 occasions = 4.00 lakhs	8 units	4.00	
4	Production & Broadcasting charges of variety health programmes on Akashvani	-	-	10.00	
5	Exhibition Panel Boards on NHM Schemes: (Standies)	1 board at Rs. 3000 each x 20 boards x 31 sets	31 sets	18.60	
6	Printing item of Local issues of the district on MH and CH.	Rs. 10000 each taluk	176 taluks	17.60	
7	Press Advertisements at the district level	Rs. 60,000/- per district	30 districts	18.00	
8	District Level Exhibitions, Tableaus on important events	8 RMNCH+A districts = 8.00 (1.00 each) + Mysore district 5.00 + Tumkur district 3.00 + Bellary district (additional) 3.00	10 districts	19.00	
9	Folk media programme @ Rs. 50,000/- per Taluk (Rs. 5000 per programme i.e. 10 programmes in each taluk)	176 taluks x 10 programmes	1760 programmes.	88.00	
10	Divisional level workshop/ training for the folk artists to perform street plays.	3.50 lakhs for each division	4 divisions	14.00	
11	Awareness programme at Sub-centre level for reducing MMR Rs. 700/-per programme	Rs. 7000/- per programme	9362 programmes	65.54	
	Sub Total			279.74	

B-10.2.2	BCC/IEC Activities for CH (Rs. In lakhs)						
FMR Code	Activity Proposed/ Name of the Activity Description	Whether New/Being Continued	Achievements if continued from previous years	Justification	Deliverables	Funding proposed	Remarks
B-10.2.2.1	Erection of New Hoardings in PHCs and CHCs of	New activity	-	Hoardings attract Masses. Hence NHM Schemes including RMNCH+A will be Publicised through Hoardings. 8	Messages on thematic issues of	100.00	(100 hoardings @ the rate Rs. 1.00 lakh for

	Districts of H.K region focusing on NHM schemes & RMNCH+A			hoardings will be located in 8 district hospitals of RMNCH+A districts, 48 hoardings will be located in CHCs/taluk hospitals & the remaining will be fixed at the primary health centres of the above mentioned 8 districts.	RMNCH+A programmes.		each hoarding) State Level activity
B-10.2.2.2	Publicity through fixing vinyl sheets behind KSRTC Buses (Belgaum and Gulbarga Divisions) in mofussil buses which includes the 8 priority districts coming under RMNCH+A	New activity	-	Publicity through buses has proved one of the most powerful ways to reach large number of people. Hence, this activity has been planned.	Messages on thematic issues of RMNCH+A programmes.	39.00	(Rs. 6,500/- per month per bus x 6 months = Rs. 39,000/-x 100 buses including production & fixing charges) State Level activity
B-10.2.2.3	Printing of educational materials on RBSK & Pentavalent vaccine (Immunization schedule) to support inter personal communication at field level.	New activity	-	For inter Personal communication educational aids are needed and also for distribution to community and field staff. -This is a new activity Folders & Posters on RBSK and on immunization schedule.	Messages on RBSK and immunization.	18.00 (8.00 + 10.00)	(Folder on RBSK and immunization @ Rs. 4 for 1.00 lakh copies each = 8.00 lakhs. Poster on RBSK and immunization @ Rs. 5 for 1.00 lakh copies each = 10.00 lakhs) State Level activity
B-10.2.2.4	Press Meets/Media Workshops/Script Development Workshop/Staff Meetings/Exposure Visits etc @ State and Regional Level. Divisional level, State level.	New activity	-	Regular Press meets, Releases, Sensitizations keep the media engaged in NHM publicity. This would help the people to become aware of the services available thereby generating the demand. Engaging the media would also help to counter the negative reporting and also rumours. Hence, these programmes are planned to keep the media abreast of the work of the	Counter acting the negative reporting and also rumours.	5.00	State Level activity

				department. - This is a new activity taken up this year.			
B-10.2.2.5	Healthy baby shows of fully immunised children in all sub centers @ Rs. 1,000/- per programme.	Continued activity.	During 2013-14 the achievement in respect of this activity is 87% up to the end of 28 th Feb 2014. The remaining programmes will be covered during march 2014.	<p>Healthy baby shows at Sub-Center level has proved to be one of the important communication sessions in the community for creating awareness to immunise children against vaccine preventable diseases. The IPC tool for educating mothers & others will be printed and supplied to the Sub-Centers. (VideB-10.2.2.3)</p> <p>Awareness activity to be conducted at every Sub-Center in Karnataka (8811 sub-centers) plus 30% extra for sub-centers in 8 HPDs (Bagalakote, Bijapur, Gadag, Bellary, Gulbarga, Koppal, Raichur & Yadgiri districts) thus an additional of 551 additional programmes/activities totalling to 9362 programmes where activity is to be conducted. Activity to be conducted by ANM and ASHA with attendance and supervision of BHEO/DyHEO/DHEO and certified reports to be submitted.</p>	Messages on vaccine preventable diseases. Importance about full immunization.	93.62	(Rs. 1000/- for each programme x 9362 programmes) District Level activity

B-10.2.2.6	Awareness programme regarding reduction of Infant Mortality rate at Sub-Centre level at Rs. 700/- per programme	New activity	-	<p>This an awareness programme at the Sub-Center level in order to educate the target group about the prevention and control of IMR.</p> <p>This is a new activity during the year 2014-15. The members of SHG, local CBOs & the mothers will be educated about the causes of infant mortality. The IPC tools for educating this target group will be folders, flip books which were</p>	Messages on various causes on infant mortality will be given to target groups in all the 9362 sessions.	65.54	(Rs. 700/- for each programme x 9362 programmes) District Level activity
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				<p>printed in previous years hence this is not included in this year. The present IMR of the state is 32 per 1000 live births (IMR is 36 in rural areas)</p> <p>Awareness activity to be conducted at every Sub-Center in Karnataka (8811 sub-centers) plus 30% extra for sub-centers in 8 HPDs (Bagalakote, Bijapur, Gadag, Bellary, Gulbarga, Koppal, Raichur & Yadgiri districts) thus an additional of 551 additional programmes/activities totalling to 9362 programmes where activity is to be conducted. Activity to be conducted by ANM and ASHA with attendance and supervision of BHEO/DyHEO/DHEO and certified reports to be submitted.</p>			
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Breakup of funds proposed for the proposed activities under CH

Sl.No	Activity /State plan	Unit cost	Quantity	Total cost (Rs.lakhs)	Details
1	Erection of New Hoardings in PHCs and CHCs of Districts of H.K region focusing on NHM schemes & RMNCH+A	100 hoardings @ the rate Rs. 1.00 lakh for each hoarding = Rs. 100.00 lakhs.	100 hoardings	100.00	Details of each item are given above
2	Publicity through fixing vinyl sheets behind	Rs. 6,500/- per month per bus x 6	100 buses	39.00	

	KSRTC Buses (Belgaum and Gulbarga Divisions) in moffussil buses which includes the 8 priority districts coming under RMNCH+A	months = Rs. 39,000/-x 100 buses including production &fixing charges = Rs. 39.00 lakhs.			
3	Printing of educational materials on RBSK & Pentavalent vaccine (Immunization schedule) to support inter personal communication at field level.	Folder on RBSK and immunization @ Rs. 4 for 1.00 lakh copies each = 8.00 lakhs. Poster on RBSK and immunization @ Rs. 5 for 1.00 lakh copies each = 10.00 lakhs = 18.00 lakhs. (8.00+10.00 lakhs)	2.00 lakh folders = Rs. 8.00 lakhs. 2.00 lakh posters = Rs. 10.00 lakhs	18.00	
4	Press Meets/Media Workshops/Script Development Workshop/Staff Meetings/Exposure Visits etc @ State and Regional Level. Divisional level, State level.	Rs. 5.00 lakhs	-	5.00	
5	Healthy baby shows of fully immunised children in all sub centers @ Rs. 1,000/- per programme.	Rs. 1000/- for each programme x 9362 programmes = 93.62 lakhs.	9362 programmes @ Rs. 1000 per programme.	93.62	
6	Awareness programme regarding reduction of Infant Mortality rate at Sub-Centre level at Rs. 700/- per programme	Rs. 700/- for each programme x 9362 programmes = 65.54 lakhs	9362 programmes @ Rs. 700 per programme.	65.54	
	Sub Total			321.16	

B-10.2.3	BCC/IEC activities/campaigns for Family Planning (FP)						(Rs. In lakhs)
FMR Code	Activity Proposed/ Name of the Activity Description	Whether New/Being Continued	Achievements if continued from previous years	Justification	Deliverables	Funding proposed	Remarks
B-10.2.3.	Printing of Education materials on FW	New activity	-	Inter Personal Communication needs educational aids. Folders on temporary	Folders containing	8.00	(Rs. 4 per each folder x 2.00

1	programme to support Inter personal communication at field level.			methods like PPIUCD/Oral pills/Nirodh will be distributed to grass root level functionaries like health assistants, Anganwadi workers & ASHAs and community for educational purposes during inter personal communication. This is a new activity for the year 2014-15.	messages on temporary methods of family welfare.		lakhs folders) State Level activity
B-10.2.3.2	Sensitization programme on NSV and male participation as well as spacing methods at sub centre level at the rate of Rs. 700/- per programme.	Continued activity	This is a continued activity. During the year 2013-14, the progress under this activity is 61% up to the end of Feb 2014. The remaining activities will be covered during March 2014.	The TFR in Bagalakote, Bijapur, Belgaum, Bellary, Bidar, Gulbarga, Koppal, Raichur & Yadgiri districts is more than the state average of 1.9. Hence 2 programmes on sensitization of NSV & male participation as well as spacing methods at sub centre level will be conducted in these districts. The total no. of Sub-Centers in these 9 districts is 2561 hence 5122 sensitization programmes will be conducted in these districts. One programme will be conducted in each of the remaining 21 districts totalling to 6250 sub centres totally 11372 programmes will be conducted. The target groups include eligible couples having 2 children & below as well as the newly married couples. The material mentioned above & the other materials printed in the previous years will be utilized for interpersonal communication.	Messages on NSV and temporary methods will be disseminated.	79.61	(Rs. 700 for each programme x 11372 programmes) District Level activity

Breakup of funds proposed for the proposed activities under family welfare (FW)

Sl.No	Activity /State plan	Unit cost	Quantity	Total cost (Rs.lakhs)	Details
1	Printing of Education materials on FW programme to support Inter personal communication at field level.	Rs. 4 per each folder x 2.00 lakhs folders = Rs. 8.00 lakhs.	2.00 lakhs folders	8.00	Details of each item are given

2	Sensitization programme on NSV and male participation as well as spacing methods at sub centre level at the rate of Rs. 700/- per programme.	Rs. 700 for each programme x 11372 programmes = Rs. 7960400	11372 programmes	79.61	above
	Subtotal			87.61	

B-10.2.4	BCC/IEC activities/ campaigns for ARSH						(Rs. In lakhs)
FMR Code	Activity Proposed/ Name of the Activity Description	Whether New/Being Continued	Achievements if continued from previous years	Justification	Deliverables	Funding proposed	Remarks
B-10.2.4.1	Advertisement through Flex on Old Hoardings throughout the state on NHM and RMNCH+A themes (51 Hoardings only)	Continued activity	Last year i.e. during the 2013-14 flexes on 51 hoardings were fixed at 51 places across the districts.	This is a continued activity. The advertisements in respect of RMNCH+A programmes including spacing methods like PPIUCD would be advertised through flex Hoardings which are already existing at 51 places across the districts. These messages will be changed twice in a year.	Messages on RMNCH+A will be depicted.	4.08	(Rs. 4000/- per flex x 2 times in the financial year with a gap of 6 months {51 + 51=102x400}) State Level activity
B-10.2.4.2	Publicity through AIR at District level (12 AIR stations)	New activity	-	There are 12 AIR stations in Karnataka located in 12 districts an amount of Rs. 1.00 lakh will be released to each district for conducting programmes on NHM through local AIR. The 12 stations are located in Gulbarga, Dharwad, Karwar, Bellary (Hospet), Bijapur, Chitradurga, Mangalore, Hassan, Kodagu (Madikeri), Mysore, Raichur & Shimoga (Bhadravathi). This is a new activity.	Messages on RMNCH+A will be broadcast through AIR.	12.00	(1 x Rs. 1.00 x 12) District Level activity
B-10.2.4.3	Sensitization of Adolescent girls	Continued activity	During the year 2013-14	This is a continued activity where in not only the self help group	Messages on RMNCH+A will	65.54	(Rs. 700/- for each

	& self help group members One programme in each sub centre at the rate Rs. 700/- on ARSH which includes RKSK & WIFS		the achievement under this programme is 98.44% the remaining will be achieved during March 2014.	members but also Peer educators will be involved in this sensitization programme. For educating the peer group members & others. The IPC tools developed by the ARSH division of the Directorate will be used for educating the target group. Awareness activity to be conducted at every Sub-Center in Karnataka (8811 sub-centers) plus 30% extra for sub-centers in 8 HPDs (Bagalakote, Bijapur, Gadag, Bellary, Gulbarga, Koppal, Raichur & Yadgiri districts) thus an additional of 551 additional programmes/activities totalling to 9362 programmes where activity is to be conducted. Activity to be conducted by ANM and ASHA with attendance and supervision of BHEO/DyHEO/DHEO and certified reports to be submitted.	be communicated in these group sessions for demand generation.		programme x 9362 programmes) District Level activity
B-10.2.4.4	Sensitization of School teachers at PHC level one programme in each PHC at the rate Rs. 700/- on ARSH	Continued activity	This is a continued activity. During the year 2013-14 the achievement under this programme is 98.33% the remaining will be achieved during March 2014.	Awareness activity to be conducted at every Primary Health Center level in Karnataka (2286 PHCs) plus 30% extra for PHCs in 8 HPDs (Bagalakote, Bijapur, Gadag, Bellary, Gulbarga, Koppal, Raichur & Yadgiri districts) thus an additional of 136 additional programmes/activities totalling to 2422 programmes where activity is to be conducted. Activity to be conducted by Medical Officer and BHEO and certified reports to be submitted. The IPC tools developed by the ARSH division of the	Messages on ARSH will be communicated to the school teachers so that it will benefit the students.	16.96	(Rs. 700/- for each programme x 2422 programmes) District Level activity

				Directorate will be used for educating the target group.			
B-10.2.4.5	Essay Competition for High School students at Taluk level at Rs. 2000/- per programme on ARSH	New activity	-	This new programme will be taken up at taluk level for high schools students in order to create awareness about physical, mental and social wellbeing of adolescents. Essay competitions will be held for the high school students. Two programmes will be conducted in each of 176 taluks totalling to 352 programmes.	Messages on ARSH will be communicated to the school students so that it will benefit the students.	7.04	(@ Rs. 2000 per programmes x 352 programmes) District Level activity
B-10.2.4.6	Debate Competition for PUC students at Taluk level at Rs .2750/- per programme on ARSH	New activity	-	This new programme will be taken up at taluk level for PUC students In order to create awareness about physical, mental & social wellbeing of adolescents essay competitions will be held for the PUC students. Two programmes will be conducted in each of 176 taluks totalling to 352 programmes.	Messages on ARSH will be communicated to the college students so that it will benefit the students.	9.68	(@ Rs. 2750 per programmes x 352 programmes) District Level activity

Breakup of funds proposed for the proposed activities under ARSH

Sl.No	Activity /State plan	Unit cost	Quantity	Total cost (Rs.lakhs)	Details
1	Advertisement through Flex on Old Hoardings throughout the state on NHM and RMNCH+A themes (51 Hoardings only)	Rs. 4000/- per flex x 2 times in the financial year with a gap of 6 months (51 + 51=102x400=4.08 lakhs)	102 flex boards	4.08	Details of each item are given above
2	Publicity through AIR at District level (12 AIR stations)	1xRs. 1.00x 12 =12.00 lakhs	12 AIR Stations	12.00	
3	Sensitization of Adolescent girls & self help group members One programme in each sub centre at the rate Rs. 700/- on ARSH which includes RKSK & WIFS	Rs. 700/- for each programme x 9362 programmes = 65.54 lakhs	9362 Programmes	65.54	
4	Sensitization of School teachers at PHC level one programme in each PHC at the rate Rs. 700/- on ARSH	Rs. 700/- for each programme x 2422 programmes = Rs. 1695400	2422 Programmes	16.96	
5	Essay Competition for High School students at Taluk level at Rs. 2000/- per programme on ARSH	@ Rs. 2000 per programmes x 352 programmes = 7.04 lakhs.	352 Programmes	7.04	
6	Debate Competition for PUC students at Taluk level at Rs .2750/- per programme on ARSH	@ Rs. 2750 per programmes x 352 programmes = 9.68 lakhs.	352 Programmes	9.68	
Sub Total				115.30	

B-10.4	Creating Awareness on declining sex ratio issue (PC & PNDT)						(Rs. In lakhs)
FMR Code	Activity Proposed/ Name of the Activity Description	Whether New/Being Continued	Achievements if continued from previous years	Justification	Deliverables	Funding proposed	Remarks
B-10.4.1	Publicity through Electronic Media/ Production and Telecasting of documentary.	New activity	-	Doordarshan and private TV channels will be engaged to create awareness on declining sex ratio and PC & PNDT act. Talk shows by activists, success stories by officers and achievers will be shared through this media to uphold the importance of female child.	Messages on importance of girl child.	15.00	(1.00 lakh for TV spots & 14.00 lakhs for telecasting in Doordarshan & private channels) State Level activity
B-10.4.2	Printing of PC & PNDT act 1994 book (with recent amendments)	New activity	-	For distribution of these to the Medical Officers of all Primary Health Centres in State, Taluk Health Officers, Community Health Taluk Hospitals, District Hospitals and members of the state and district PC & PNDT act committees. This will help in IPC. This is a new activity.	Conveying the provision of the act.	2.50	(10000 copies (5000 copies in Kannada and 5000 copies in English) @ Rs. 25 for each copy) State Level activity
B-10.4.3	Publicity through laminated sun boards (Size 2 ½ X 3½ feet) on PC & PNDT act 1994	New activity	-	These boards will be exhibited in private hospitals where scanning facilities are available as well as in Government Hospitals where scanning is done in order to create awareness about PC & PNDT act forbidding the selection of sex.	Messages on importance of girl child and punishments for violation of act.	2.50	(Rs. 100/each board x 2500 boards) State Level activity

B-10.4.4	Publicity through laminated Posters on PC & PNDT act 1994	New activity	-	For distribution in all the sub centers, PHCs, CHCs, District hospital and filed level staff, for exhibiting the same in the areas to create awareness about the act. This will help in IPC. This is a new activity.		Messages on importance of girl child and punishments for violation of act.	0.75	(Rs. 5/each poster x 15000 posters) State Level activity	
B-10.4.5	PC&PNDT Workshops for ASHAs, Anganwadi workers & NGOs at Taluk level	Continued activity	This is a continued activity. Last year the achievement under this activity is 73%. The remaining activity will be covered during March 2014.	This workshop will help the staff in educating the community about the adverse conditions of skewness in the gender ratio of boys & girls. The literatures produced during the last year will be utilized during the workshops for educational purposes. This activity will be held in 10 districts depending upon the sex ratio. Two workshops will be held in each taluk. The list of district, no. of taluks and no. of programmes is given below:		Messages on importance of girl child and punishments for violation of act.	9.86	(Rs.8500/- per workshop x 116 workshops) District Level activity	
				Sl. No	District	No. of Taluks	No. of workshops @ Rs. 8500 per Programme No. of Programmes (2 programmes for each taluk)		
				1	Bagalkote	6	12		
				2	Belgaum	10	20		
				3	Bellary	7	14		
				4	Bijapur	5	10		
				5	Chamarajanagar	4	8		
				6	Gulbarga	7	14		
				7	Koppal	4	8		
				8	Mandya	7	14		
				9	Raichur	5	10		
				10	Yadagir	3	6		
				Total		58	116		

Breakup of funds proposed for the proposed activities under PC & PNDT

Sl.No	Activity /State plan	Unit cost	Quantity	Total cost (Rs.lakhs)	Details
1	Publicity through Electronic Media/ Production and Telecasting of documentary.	1.00 lakh for TV spots & 14.00 lakhs for telecasting in Doordarshan & private channels = Rs. 15.00 lakhs	-	15.00	Details of each item are given above
2	Printing of PC & PNDT act 1994 book (with recent amendments)	10000 copies (5000 copies in Kannada and 5000 copies in English) @ Rs. 25 for each copy totalling to Rs. 2.50 lakhs.	10000 copies x Rs. 25 each copy	2.50	
3	Publicity through laminated sun boards (Size 2 ½ X 3½ feet) on PC & PNDT act 1994	Rs. 100/each board x 2500 boards = Rs. 2.50 lakhs.	2500 boards	2.50	
4	Publicity through laminated Posters on PC & PNDT act 1994	Rs. 5/each poster x 15000 posters = Rs. 0.75 lakhs.	15000	0.75	
5	PC&PNDT Workshops for ASHAs, Anganwadi workers & NGOs at Taluk level	Rs.8500/- per workshop x 116 workshops =Rs. 9.86 lakhs.	116 workshops	9.86	
Sub Total				30.61	

B-10.5	Any other activities						(Rs. In lakhs)
FMR Code	Activity Proposed/ Name of the Activity Description	Whether New/Being Continued	Achievements if continued from previous years	Justification	Deliverables	Funding proposed	Remarks
B-10.5.1	Publishing of Kutumba varthe quarterly Magazine in attractive form with 52 pages	Continued	During 2013-14 there is 100% progress.	Kutumba varthe quarterly magazine would be the face & forum of the department to share its various activities, latest developments etc. Hence, a magazine retaining the old name kutumba with a new look & vigour will be brought out regularly.	Topics on Health & Family Welfare to be supplied to all health institutions of the department and care providers at grass root level.	20.00	(50,000 copies x 4 quarters x @ Rs.10) State Level activity
B-10.5.2	Advertisement in Daily Newspapers and magazines on NHM	Continued activity	Regular advertisement have been given & achievement is 100%	Regular advertisements on various programmes of NHM will be given in daily newspapers and magazines in order to spread the message of the programmes.	Messages on NHM	50.00	State Level activity
B-10.5.3	Social media	New Activity	-	Social Media such as through the Internet, social sites such as Facebook, Twitter, etc. mobile communication will be designed for NHM programmes, especially RMMCH+A initiatives. Since these are the new age media and need to be harnessed to further NHM goals and inform the public about the services and programmes available, especially RMNCH+A initiatives	Messages especially on RMNCH+A initiatives	50.00	State Level activity

B-10.5.4	Major Exhibitions in the state	New Activity	-	The State capital hosts numerous national and international conferences and exhibitions. It is planned to exhibit the services and programmes of NHM, Karnataka especially RMNCH+A at these forums and also to publicise the achievements and developments in the health domain.	Organising exhibitions for giving highlights of achievement of the department	10.00	State Level activity																																																
B-10.5.5	Awareness programme about Fluorosis to field staff & SHGs @ the rate of Rs. 700/- per programme	New Activity	-	Awareness Programmes will be taken up to create awareness about the high content of fluoride in the water, its impact on the life of people and prevention of fluorosis. IPC sessions will be taken up in 49 taluks of 10 districts which rank high in fluoride content in the water. The sessions will be jointly conducted for SHGs and Junior Health Assistants at Sub-Centre Level. The list of districts and taluks are given below:	Awareness about hazards of excess of fluorine content in the water	0.69	(Rs. 700/- x 2 programme per each taluk x 49 taluks) District Level activity																																																
				<table> <tr> <th>Sl.</th> <th>District</th> <th>No. of Taluks</th> <th>No. prog.</th> </tr> <tr><td>1</td><td>Bangalore (U)</td><td>3</td><td>6</td></tr> <tr><td>2</td><td>Chitradurga</td><td>3</td><td>6</td></tr> <tr><td>3</td><td>Kolar</td><td>5</td><td>10</td></tr> <tr><td>4</td><td>Tumkur</td><td>4</td><td>8</td></tr> <tr><td>5</td><td>Chikkaballapur</td><td>6</td><td>12</td></tr> <tr><td>6</td><td>Bellary</td><td>3</td><td>6</td></tr> <tr><td>7</td><td>yadgiri</td><td>3</td><td>6</td></tr> <tr><td>8</td><td>Mandya</td><td>7</td><td>14</td></tr> <tr><td>9</td><td>Belgaum</td><td>10</td><td>20</td></tr> <tr><td>10</td><td>Gadag</td><td>5</td><td>10</td></tr> <tr> <td colspan="2">Total</td> <td>49</td> <td>98</td> </tr> </table>	Sl.	District	No. of Taluks	No. prog.	1	Bangalore (U)	3	6	2	Chitradurga	3	6	3	Kolar	5	10	4	Tumkur	4	8	5	Chikkaballapur	6	12	6	Bellary	3	6	7	yadgiri	3	6	8	Mandya	7	14	9	Belgaum	10	20	10	Gadag	5	10	Total		49	98			
Sl.	District	No. of Taluks	No. prog.																																																				
1	Bangalore (U)	3	6																																																				
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10	Gadag	5	10																																																				
Total		49	98																																																				

B-10.5.6	Awareness programme regarding blindness at sub centre level @ rate of Rs. 700/-	New Activity	-	For the development of the children one of the important sense organs i.e., eye is needed and education of communities is atmost important and appropriate in this thematic area. The awareness campaigns are panned to educate the community in order to prevent blindness. The IPC tool developed by the office of the Joint Director (control of blindness) will be utilized for these Group IPC sessions conducted by ASHAs and ANMs at Sub-centre level. The target group will be SHGs & local CBOs. This activity will be taken up in 12 districts covering 65 taluks. The list of districts and taluks are given below:	Awareness about the causes & prevention of early childhood blindness as well as Retinopathy in prematurity of children	0.91	(Rs. 700/- x 2 programme per each taluk x 65 taluks) District Level activity																																																								
				<table><tr><td>Sl.</td><td>District</td><td>No. of Taluks</td><td>No. prog.</td></tr><tr><td>1</td><td>Kolar</td><td>5</td><td>10</td></tr><tr><td>2</td><td>Gulbarga</td><td>7</td><td>14</td></tr><tr><td>3</td><td>Koppal</td><td>4</td><td>8</td></tr><tr><td>4</td><td>Bidar</td><td>5</td><td>10</td></tr><tr><td>5</td><td>Raichur</td><td>5</td><td>10</td></tr><tr><td>6</td><td>Bellary</td><td>7</td><td>14</td></tr><tr><td>7</td><td>yadgiri</td><td>3</td><td>6</td></tr><tr><td>8</td><td>Kodagu</td><td>3</td><td>6</td></tr><tr><td>9</td><td>Belgaum</td><td>10</td><td>20</td></tr><tr><td>10</td><td>Bagalkot</td><td>6</td><td>12</td></tr><tr><td>11</td><td>Bijapur</td><td>5</td><td>10</td></tr><tr><td>12</td><td>Gadag</td><td>5</td><td>10</td></tr><tr><td></td><td>Total</td><td>65</td><td>130</td></tr></table>	Sl.	District	No. of Taluks	No. prog.	1	Kolar	5	10	2	Gulbarga	7	14	3	Koppal	4	8	4	Bidar	5	10	5	Raichur	5	10	6	Bellary	7	14	7	yadgiri	3	6	8	Kodagu	3	6	9	Belgaum	10	20	10	Bagalkot	6	12	11	Bijapur	5	10	12	Gadag	5	10		Total	65	130			
Sl.	District	No. of Taluks	No. prog.																																																												
1	Kolar	5	10																																																												
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11	Bijapur	5	10																																																												
12	Gadag	5	10																																																												
	Total	65	130																																																												

B-10.5.7	Awareness programme about Non Communicable Diseases at sub centre level	New activity	-	The awareness programmes are planned at sub centre levels at the rate of 2 programmes in each taluk for educating the community about the science & symptoms, prevention & control as well as treatment of Non Communicable Diseases in order to reduce the prevalence of Non Communicable Diseases in the community. This is for this year. Awareness programmes on Non-Communicable Diseases are planned at sub-centre levels at 101 taluks across Karnataka in 18 districts only.	Awareness about the causes, symptoms & prevention & control of NCDs	1.42	(Rs. 700/- x 2 programme per each taluk x 101 taluks) District Level activity																																																																																
				<table><tr><td>Sl.</td><td>District</td><td>No. of Taluks</td><td>No. prog.</td></tr><tr><td>1</td><td>Bangalore (R)</td><td>4</td><td>8</td></tr><tr><td>2</td><td>Bangalore (u)</td><td>4</td><td>8</td></tr><tr><td>3</td><td>Kolar</td><td>5</td><td>10</td></tr><tr><td>4</td><td>Shimoga</td><td>7</td><td>14</td></tr><tr><td>5</td><td>Ramnagar</td><td>4</td><td>8</td></tr><tr><td>6</td><td>Koppal</td><td>4</td><td>8</td></tr><tr><td>7</td><td>Bellary</td><td>7</td><td>14</td></tr><tr><td>8</td><td>Yadgir</td><td>3</td><td>6</td></tr><tr><td>9</td><td>Mandya</td><td>7</td><td>14</td></tr><tr><td>10</td><td>D Kannada</td><td>5</td><td>10</td></tr><tr><td>11</td><td>chikamagalur</td><td>7</td><td>14</td></tr><tr><td>12</td><td>Kodagu</td><td>3</td><td>6</td></tr><tr><td>13</td><td>Udupi</td><td>3</td><td>6</td></tr><tr><td>14</td><td>Belgaum</td><td>10</td><td>20</td></tr><tr><td>15</td><td>Bijapur</td><td>5</td><td>10</td></tr><tr><td>16</td><td>Gadag</td><td>5</td><td>10</td></tr><tr><td>17</td><td>Haveri</td><td>7</td><td>14</td></tr><tr><td>18</td><td>U kannada</td><td>11</td><td>22</td></tr><tr><td></td><td>Total</td><td>101</td><td>202</td></tr></table>	Sl.	District	No. of Taluks	No. prog.	1	Bangalore (R)	4	8	2	Bangalore (u)	4	8	3	Kolar	5	10	4	Shimoga	7	14	5	Ramnagar	4	8	6	Koppal	4	8	7	Bellary	7	14	8	Yadgir	3	6	9	Mandya	7	14	10	D Kannada	5	10	11	chikamagalur	7	14	12	Kodagu	3	6	13	Udupi	3	6	14	Belgaum	10	20	15	Bijapur	5	10	16	Gadag	5	10	17	Haveri	7	14	18	U kannada	11	22		Total	101	202			
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B-10.5.8	Evaluation of IEC Activities	New Activity	-	Evaluation of IEC activities will be under taken in order to know the impact of educational activities, sources of information and the knowledge and attitude of the target groups & monitor behaviour change. This will help in planning for the subsequent activities. Evaluation helps to know the outcome of deliverables.	Conducting monitoring and evaluation studies	15.00	State Level activity																																																																																

Breakup of funds proposed for the proposed activities under Any other activities

Sl.No	Activity /State plan	Unit cost	Quantity	Total cost (Rs.lakhs)	Details
1	Publishing of Kutumba varthe quarterly Magazine in attractive form with 52 pages	50,000 copies x 4 quarters x @ Rs.10	2.00 lakh copies @ Rs.10	20.00	Details of each item are given above
2	Advertisement in Daily Newspapers and magazines on NHM	50.00	-	50.00	
3	Social media	50.00	-	50.00	
4	Major Exhibitions in the state	10.00	-	10.00	
5	Awareness programme about Fluorosis to field staff & SHGs @ the rate of Rs. 700/- per programme	Rs. 700/- x 2 programme per each taluk x 49 taluks	98 programmes @ Rs. 700/-	0.69	
6	Awareness programme regarding blindness at sub centre level @ rate of Rs. 700/-	Rs. 700/- x 2 programme per each taluk x 65 taluks	130 programmes @ Rs. 700/-	0.91	
7	Awareness programme about Non Communicable Diseases at sub centre level	Rs. 700/- x 2 programme per each taluk x 101 taluks	202 programmes @ Rs. 700/-	1.42	
8	Evaluation of IEC Activities	Rs. 15.00	-	15.00	
	Sub Total			148.02	

Observation of World Health Day

Activity: Observation of World Health Day.

It is a new activity.

Justification:

World Health Day is observed globally on 07 April every year. The World Health organisation releases the theme, slogan and message related to health and environmental issues. It is the duty of the health organisations to take up the released slogan, message, theme and work on it seriously. The health department in particular should play a major role in spreading the message and information and create awareness among the general public, Training the health personnel and capacity building play a major role in the spread of the message. The theme for this year is "vector borne diseases" and slogan is "small bite big threat". Every year World Health day is celebrated with the involvement of other departments like Education department, social welfare department, Panchayatha raj institutions and others. The Health department play a major role in creating awareness, organising various training programmes for the school children/ teachers / health personal etc. Department will implement various activities during the World Health day celebration at District & State level. Hence this activities propose.

Deliverables: Awareness campaign, Jada, Mass media programmes, SA writings at Schools and colleges, Training of Health providers and others stake holders

Funding proposed

Sl. No	Activities	No. of Units	Cost per unit	Total Cost	FMR Code	Remarks
1	One day orientation work shop/training at State level	1	75,000/-	0.75 lakhs	B.10.5	This amount will be utilized for workshop and

2	One day orientation work shop/training at District level	30	50,000/-	15.00 lakhs	B.10.5	awareness campaign
Total				15.75 lakhs		

ABSTRACT

FMR Code	Division / section	Total Rs. In lakhs
B-10.1	Strengthening of BCC/IEC Bureaus at District level	164.76
	Strengthening of BCC/IEC Bureaus at State level	8.72
B-10.2.1	BCC/IEC Activities for MH	279.74
B-10.2.2	BCC/IEC Activities for CH	321.16
B-10.2.3	BCC/IEC activities/campaigns for Family Planning (FP)	87.61
B-10.2.4	BCC/IEC activities/ campaigns for ARSH	115.30
B-10.4	Creating Awareness on declining sex ratio issue (PC & PNDT)	30.61
B-10.5	Any other activities	148.02
B-10 .5	World population Day	15.75
	Grand total	1171.67

Classification of Activities according to Media

FMR Code	Division / section	State Level					District Level					Grand Total				
		Mass media	Mid Media	IPC	Others including training	Total	Mass media	Mid Media	IPC	Others including training	Total	Mass media	Mid Media	IPC	Others including training	Total
B-10.1	Strengthening of BCC/IEC Bureaus at district level					0				164.76	164.96	0	0	0	164.76	164.76
	Strengthening of BCC/IEC Bureaus at State level				8.72	8.72					0	0	0	0	8.72	8.72
B-10.2.1	BCC/IEC Activities for MH	57.6		14		71.6	54.6	88	65.54		208.14	112.2	88	79.54	0	279.74
B-10.2.2	BCC/IEC Activities for CH	157		5		162			159.16		159.16	157	0	164.16	0	321.16
B-10.2.3	BCC/IEC activities/campaigns for Family Planning (FP)	8				8			79.61		79.61	8	0	79.61	0	87.61
B-10.2.4	BCC/IEC activities/campaigns for ARSH	4.08				4.08	12		99.22		111.22	16.08	0	99.22	0	115.30
B-10.4	Creating Awareness on declining sex ratio issue (PC & PNMT)	20.75				20.75			9.86		9.86	20.75	0	9.86	0	30.61
B-10.5	Any other activities	130				130			3.02	15	18.02	130	0	3.02	15	148.02
B.10.5	Observation of World Health Day		0.75			0.75		15.00			15.00		15.75			15.75
	Grand total	377.43	0.75	378.18	756.36	405.9	1918.62	15	3852.24	7704.48	757.37	16166.33	103.75	32436.41	64872.82	1171.67

Classification of Activities according to Media

FMR Code	Division / section	State Level	District Level	Total
B-10.1	Strengthening of BCC/IEC Bureaus at District level	0	164.76	164.76
	Strengthening of BCC/IEC Bureaus at State level	8.72	0	8.72
B-10.2.1	BCC/IEC Activities for MH	71.60	208.14	279.74
B-10.2.2	BCC/IEC Activities for CH	162	159.16	321.16
B-10.2.3	BCC/IEC activities/campaigns for Family Planning (FP)	8.00	79.61	87.61
B-10.2.4	BCC/IEC activities/ campaigns for ARSH	4.08	111.22	115.30
B-10.4	Creating Awareness on declining sex ratio issue (PC & PNDT)	20.75	9.86	30.61
B-10.5	Any other activities	130.00	18.02	148.02
B.10.5	Observation of World Health Day	0.75	15.00	15.75
	Grand total	405.9	765.77	1171.67

B.12 Referral transport (Nagu Magu)

Introduction:

"Nagu Magu" introduced in 2013-2014 is a drop back facility. In this programme after delivery, mother and child are sent back home through "Nagu Magu" drop back ambulances. In case mother or child develops complications and requires referral services, this ambulance will be used to shift mother and child to higher centers. This facility can also be used for bringing sick child and mother to health institution if she develops any complications during post-partum period for 30 days. This "Nagu Magu" programme is to encourage institutional deliveries and to reduce NMR and MMR.

Value added services are added in the ambulances to promote breast feeding, to counsel mother for family planning and to educate about warning signs and when to seek health care.

Objectives:

1. To promote Institutional deliveries.
2. Timely referral of mother and child.
3. To prevent sepsis and hypothermia to the child.

Activity Proposed: Referral Transport Services.

Name of the Activity: "Nagu-Magu" Drop Back Ambulances

Whether New or being continued: Continued activity

Achievement if continued from previous year:

200 ambulances are procured and distributed to FRUs and District hospitals. Appointed 1 driver per vehicle on contractual basis through outsourced agency, linking these ambulances to call centre is under process.

Justification:

Around 9 lakhs deliveries occurs in our state, 98.8% are institutional deliveries, among this 70 % of deliveries occurs in public sectors, out of which 70% occurs in rural areas. We are expecting to drop **back** 5 lakh of these mothers and cured children from SNCUs, NBSUs.

Deliverables:

Around 5 lakhs mother and child are going to be benefited by this project.

Funding proposed:

Sl. No.	Activity	No of Units*	Unit cost	Amount proposed	FMR Code	Remarks
1	HR Drivers salary	200	0.12	288.00	B.12	Drivers per vehicle Salary @ rate of 11000/- per month
2	POL and vehicle maintenance	200	200 x 40000 = 80000 and 25000 x 200 x 12 months = 600.00	680.00	B.12	Fuel 25000/- per vehicle per month, Servicing and oil change 4 time in the year @ of Rs.40000 per vehicle
	Total			968.00		

JANANI SURAKSHA VAHINI (JSV)**Introduction:**

This Programme is being implemented in Karnataka since 2007-08, in this Programme free referral transport between facilities is ensured for pregnant women during delivery and sick infants with the main intention of promoting institutional deliveries to reduce Maternal and to reduce Infant Deaths. One of the Ambulances of the CHC/Taluk Hospital/District Hospital is designated as JSV; it functions round the clock with 3 drivers who work on 8 hour shifts. Under this Programme, the corresponding number of vacant regular drivers' post is filled up through provision of drivers on contract from Man-Power Agencies to ensure 3 drivers per Ambulance. Each JSV Ambulance is equipped with a mobile phone to enable the drivers to provide effective referral service and the recurring mobile phone bill charges are paid through JSV budget. This 24 X 7 hours JSV referral service ensures that pregnant women who develop complications during or after delivery and sick infants who need referral transport to higher centers for specialized care are transported quickly free of cost. The POL for these JSV Ambulances is met out of State Budget/JSSK funds/Untied Fund/Users' charges.

Objectives:

1. To promote Institutional Deliveries.
2. To ensure an assured timely free referral transport at Government Hospitals for shifting pregnant women and sick infants who develop complications after delivery to higher centres.
3. To prevent deaths and complications due to delayed referral of pregnant women and infants who develop complications during or after labour in a lower level Hospitals.
4. To reduce out of pocket expenditure for the families of pregnant women and infants.

Strategies:

1. To establish at least one JSV ambulance at District hospital / Taluka hospital / CHC with 3 drivers along with mobile phone facility.
2. To ensure free transportation for pregnant women and infants between the health facilities.

JSV is functionalized using State Government Ambulances and there is no capital cost investment from NHM, 3 Drivers are ensured for each JSV which functions 24X7. If 3 Government regular drivers are not available for these JSVs, corresponding number of drivers are provided by NHM under this Programme by outsourcing them from Man-Power Agencies.

108 Ambulances transport cases from the community to Hospitals, as they have a limited area of service they cannot transport cases between Hospitals. JSVs mainly transport Pregnant Women and Sick Infants between Hospitals from CHC/Taluk/District Hospitals to Medical College/Super Specialty Hospitals. JSVs also transport other emergency cases.

Each JSV is equipped with a Mobile Phone and the driver of JSV will be in charge of the phone, he hands over the phone to the driver who takes charge from him. For each mobile phone recurring cost of Rs.250/month is provided towards phone bill.

Activity Proposed: provision of Drivers to one of the Ambulances of CHC/Taluk Hospital/District Hospital designated as Janani Suraksha Vahini for referral transport of pregnant women during delivery and sick infants between hospitals to reduce Maternal and Infant deaths.

Name of the Activity: Janani Suraksha Vahini

It is a continued activity

Achievements: During 2013-14, 180 JSVs are functional in the State with 363 out sourced contract drivers and 177 regular drivers. The details of number of JSVs and the drivers is furnished in Annexure-I.

Details of Pregnant Women and other Emergency Cases shifted by JSVs from April 2013 up to October 2013

No of JSV Ambulances	No of Pregnant Women Shifted between Hospitals	No of Infants Shifted between Hospitals	No other Emergency cases shifted between Hospitals
180	22534	1776	73160

Justification: 108 Service shifts patients from the accident spot & residence of the patients to the hospitals only, there is no designated vehicle to transport pregnant women during complications and sick infants to higher centres free of cost, as there is acute shortage of drivers at FRUs in the State. Hence, in JSV Programme a vehicle is designated for referral service of pregnant women and sick infants by ensuring 24 X 7 drivers availability by outsourcing drivers with JSV Budget.

Deliverables: Under this Programme all pregnant women who develop complications during or after delivery and sick infants who need care at higher facilities will be transported free of cost immediately.

Budget proposed for JSV Programme for 2014-15

During 2013-14, the Unit Cost of JSV drivers approved for the districts is Rs.7,500, with this amount the Man-Power agencies are paying only Rs.4,600/- take home salary for JSV drivers, well below the eligible minimum wages, this has led to very high attrition rate of JSV drivers, thereby hampering JSV services in the State. Hence during 2014-15, the unit cost proposed for each JSV driver/month is Rs.12,000 per month.

Funding proposed

Sl. No.	Activity	No. of units	Unit cost	Amount proposed	FMR code
1.	Drivers salary	363	1.44 lakhs (Rs.12,000X12)	522.72	B-12
2.	Mobile Phone Bill Recurring Cost/JSV Vehicle	180	Rs.3,000 (Rs.250X12)	5.40	

Budget Proposed for JSV Programme during 2014-15 is Rs.528.12 lakhs

Annexure – I

Details of JSVs and Drivers under JSV Programme as on 30th November 2013					
SI No	District	No of JSVs Functional	Regular Drivers	Outsourced JSV Drivers	Total
1	Bangalore (U)	3	3	6	9
2	Bangalore (R)	4	6	6	12
3	Chikkaballapur	6	7	11	18
4	Chitradurga	6	5	13	18
5	Davanagere	6	5	13	18
6	Kolar	6	10	8	18
7	Ramanagara	4	4	8	12
8	Shimoga	6	6	12	18
9	Tumkur	9	4	23	27
10	Bagalkote	10	10	20	30
11	Belgaum	11	11	22	33
12	Bijapur	5	5	10	15
13	Dharwad	2	2	4	6
14	Gadag	6	6	12	18
15	Haveri	8	8	16	24
16	Uttara Kannada	9	4	23	27
17	Bellary	6	11	7	18
18	Bidar	5	3	12	15
19	Gulbarga	6	6	12	18
20	Yadgir	3	2	7	9
21	Koppal	7	3	18	21
22	Raichur	5	5	10	15
23	Chamarajanagar	4	4	8	12
24	Chikkamagalore	5	5	10	15
25	Dakshina Kannada	6	9	9	18
26	Hassan	8	8	16	24
27	Kodagu	5	4	11	15
28	Mandya	6	7	11	18
29	Mysore	9	10	17	27
30	Udupi	4	4	8	12
	Total	180	177	363	540

B.14 INNOVATIONS:

Universal Health Coverage

Background:

Universal Health Coverage is increasingly seen as being critical to delivering better health and as a unifying goal for health system development it contributes to, benefits from, and provides a way of measuring progress on sustainable development. It has two inter related components – **coverage with needed health services** (preventive, promotive curative, rehabilitative and palliative care) and **coverage with financial risk protection for everyone**.

Steady progress has been towards universal health coverage globally, in terms of increasing with health services related to the Millennium Development Goals, in levels of financial risk protection, and in health system strengthening more broadly.

The planning commission of India in its 12th Five year plan said implementing Universal Health Coverage is to provide its citizen assured access to a defined essential range of medicines and treatment at an affordable price, which should be free for a large percentage of population, this is the core concept of Essential Health Package (EHP), the heart of UHC.

The Twelfth Plan strategy outlines the first step in moving toward Universal Health Care (UHC). All over the world, the provision of some form of universal health coverage is regarded as a basic component of social security. There are different ways of achieving this objective and country experiences vary. We need to ensure much broader coverage of health services to provide essential health care and **we need to do it through a system which is appropriate to our needs and within our financial capability.**

Definition:

According to WHO Universal Health coverage is defined as access to key preventive, promotive, curative and, rehabilitative health interventions for all at an affordable cost.

Goal for UHC:

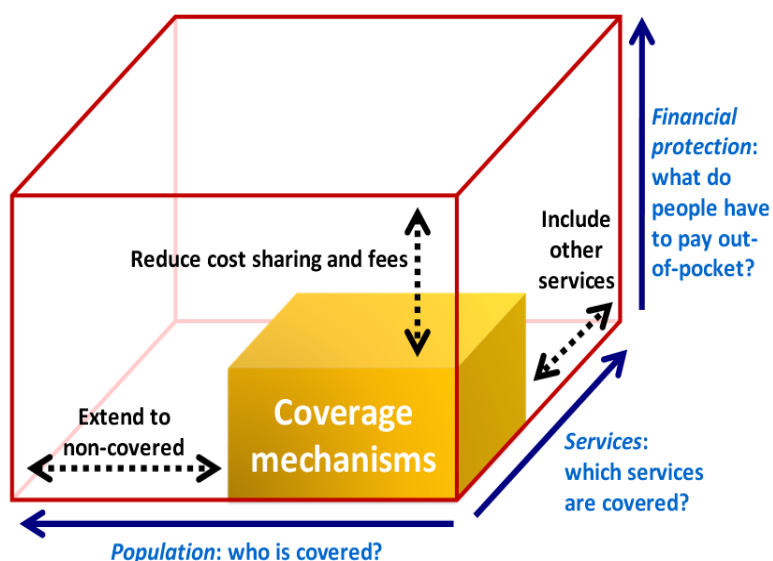
- 1) Ensuring that people get the health services at reasonable quality with minimal direct payments, especially for population that needs services the most.
- 2) A stronger health system with improved infrastructure and better stewardship of private and non-government sectors

Objective:

Universal access to equitable affordable and quality health care services, which is accountable and responsive to the needs of the people.

Concept of UHC:

Towards universal coverage



Challenges:

1. How to combine public and private providers effectively for meeting UHC goals in a manner that avoids perverse incentives, reduces provider induced demand. Yet meets objectives?
2. How to integrate different types and levels of services; public health and clinical, preventive and promotive interventions along with primary, secondary, and tertiary clinical care—so that continuum of care is assured?

Karnataka is planning to roll out Universal Health Coverage in 2 districts, namely, Raichur and Mysore. A State level workshop in this regard was conducted in the month of September 2013 and District Level Workshop involving all stakeholders was completed in Mysore and Raichur in October 2013. G.O has been issued vide G.O Number: HFW 171 FPR 2013 dated: 20-12-2013 Bangalore, for Piloting UHC at Mysore & Raichur. State level Task force and District level task force are formed which will provide overall guidance, supervision and monitoring to take forward and roll out Universal Health Coverage in selected districts.

The PHFI (Public Health Foundation of India New Delhi) has been identified as a Technical agency to facilitate the work of UHC with various departments for establishments at the state and District level. The PHFI roll will be providing technical assistance in partnership with the state Government and other stake holders.

Strategies:

- Piloting UHC in the selected districts and issue of Government order
- Sensitization and advocacy workshop at various levels.

- Establishment of task force at State and District level.
- Assessment study at Piloted Districts.
- Development of essential Health package.
- Monitoring and evaluation
- IEC and BCC activities
- Training and capacity building

Achievements:

One state level Stake holders meeting was conducted in the month September 2013 and Two district level Stake holders meetings were held in Raichur and Mysore in the month October 2013. G.O, is issued for Piloting UHC in Two Districts of Karnataka i.e Mysore and Raichur. PHFI is identified as a nodal agency for Technical assistance

ROP approval was received for Rs. 100 Lakhs for the studies and base line assessments in the second supplementary PIP in the month November 2013. The process of hiring consultants for UHC and hiring of consultancy firm for assessment study was initiated and not able to complete because of declaration of Elections. It is propose to take up various activities and studies for the year 2014-15

Activities proposed for 2014-15

- 1) Advocacy for UHC
- 2) Assessment studies
- 3) Capacity building workshop at State level and District level.

1) Advocacy for UHC:

This is a new activity

The concept of UHC will be demand driven in the State and hence advocacy is a key element in the preparation for the roll out of the scheme. Further, advocacy will also be required to disseminate the situational assessment/analysis with the stakeholders. Once the options for Essential Health Package (EHP) are brought out, advocacy would again be required to share this with the stakeholders and to involve them in selecting options. Advocacy efforts will be targeted on specific groups such as elected representatives, public officials, media, professional associations, civil society groups and NGOs etc. It is planned to select agencies for advocacy on UHC in these districts through an open bidding process. The advocacy strategy will involve developing content, material and tools for advocacy and sensitization sessions/workshops targeted on different groups as follows:

1. Elected representatives such as MLAs, MLCs, MPs, ZP, TP, GP members as well as members of VHSNC and RKS. Representatives from major political parties at the District and Block levels.

2. Media representatives from Kannada and English newspapers, radio, TV channels as well as representatives from State Department of Information & Publicity, Doordarshan, AIR, DAVP etc.
3. Public officials such as District, Block and Hobli level officers from Revenue, Panchayati Raj, AYUSH, Women & Child Development, Education, Agriculture, PWD, Social Welfare, Youth Services, Police etc.
4. Frontline functionaries of Health Department such as ANM, ASHA, Staff Nurse etc.
5. Professional Associations such as IMA, FOGSI, IAP, Karnataka Government Medical Officers Association, Karnataka Government Employees Association etc.
6. Private and Corporate Hospitals, Medical Colleges, Diagnostic Laboratories, Clinics, Practitioners of other systems of Medicine etc.
7. Captains of Large, Medium and Small Scale Industry and associations representing such people such as Chamber of Commerce, FICCI, CII, Association of Small and Medium Scale Entrepreneurs etc.,
8. Labour and Trade Unions, Call Centre Employees Associations, Taxi- Auto drivers Associations, Associations representing other unorganized sector etc
9. Agriculture Produce and Marketing Committees, Karnataka Milk Federation, Horticulture Associations and Farms, Agriculture Labour Groups etc.,
10. Civil Society groups, Self Help Groups and NGOs which are active in fields of Public Health, Education, Women and Child Rights, Gender, Anti-Dowry, Human Rights etc.,

It is planned to have specific advocacy sensitization sessions of 3-4 hour duration for each of these groups at various levels such as District, Block and at Hobli/PHC. It is estimated that in each district about 50-60 advocacy sessions will be required. Each advocacy workshop will require a minimum budgetary outlay of Rs.50,000 for about 50-75 participants, including hall hiring charges, stage/dais arrangements, seating arrangements, backdrop, food and beverages, audio-visual equipment/systems, pamphlets etc. From these advocacy sessions, potential champions (about 40-50 per district) would be identified who would in turn be invited to participate in a 2 day workshop on UHC at the State level. It is also planned to develop two 15-20 minute duration documentaries on UHC which will be shown to the participants during sensitization sessions. Apart from the above, advocacy campaigns using folk media are also planned in each district. It is planned to use local 'Rangayana' artistes for folk media campaign in both the districts especially in markets, fairs, temple festivals etc. In Mysore specific advocacy campaigns will be planned at the time of Dussara. Newspaper advertisements will also be made specifically in local media in the above mentioned two districts as part of advocacy efforts.

Achievements:

Three advocacy meeting are conducted One at state level and Two at District level (Mysore & Raichur)

Justification:

As the UHC is a new concept there is a need to create awareness in the community among stake holders and Health care providers. Hence this activity is proposed.

Funding proposed

S.No	Activity	Number of Events (Number of units)	Unit Cost (Rs)	Total Cost (Rs)	FMR code
1.	Advocacy Sessions	120	50,000	60,00,000	B14.2
	TOTAL			60,00,000	

Assessment Studies as a preparation for UHC: This is a continued activity

Apart from advocacy and awareness generation, some specific studies are proposed as part of baseline assessment before the roll out of UHC in the pilot districts as given below:

1. Coverage of population and services in the districts, Quality of care of services in the districts, Availability of medicines in public facilities, State Health Accounts and District Health Accounts, Innovative approaches for delivery of health care It is proposed to conduct these studies through research agencies or through reputed Medical Colleges (Department of PSM/Community Medicine). It is estimated that each study will cost approximately Rs. 15,00,000. Thus a total of Rs. 30,00,000 is proposed for this component in 2 district.

Achievements:

Preparation of EOI, TOR, Bidding document and agreement document are under preparation. ROP approval was received in the second supplementary PIP in the month of November 2013 and hence not able to utilize the amount because of declaration of Lokasabha election.

Justification:

Baseline assessment of various parameters is essential to take up any new innovative Health schemes for implementation in the Piloted districts. UHC is a new concept to provide quality Health care services to the community. In order to know the situation of basic Health services available, various assessment studies are planned. Hence this activity is proposed.

Funding proposed

Sl.No	Activity	No. of Units	Unit cost in Lakhs	Total Budget in Lakhs	FMR code	remarks
1.	Coverage of population, Quality of care of services, Availability of equipments,	2	Rs. 15.00	Rs. 30.00	B.14.2	Mysore & Raichur

	medicines, and other logistics in Health facilities , and services in the districts					
	TOTAL			Rs. 30-00		

Capacity building:It is a new activity

It is proposed to have Two day, off-site, residential workshop for Departmental persons and other stake holders at state level and District level with specific focus on the UHC Pilot Districts of Raichur and Mysore. The number of participant for each workshop will be 50 and the cost of the workshop is Rs. 1.5 Lakhs which includes workshop course material, logistic arrangements and refreshments. The nodal officer nominated for UHC implementation at State level and District level are to be trained at National level and International level to implement the programme effectively. They are supposed to visit the other Countries where UHC is implemented for study purpose.

Justification:

As the UHC is a new concept, there is a need to sensitize health care providers and stake holders in the Piloted Districts of Mysore & Raichur. The officials implementing UHC are to be deputed for training and study tours for proper effective implementation of the programme hence this activity is proposed.

Funding proposed:

Sl.No	Activity	No. of units	Unit cost	Total Amount	FMR code	Remarks
1	Capacity building workshops at state level	1	Rs. 2.5 Lakhs	Rs. 2.5 Lakhs	B.14.2	50 members batch 1 workshop for 2 days is proposed at state level
2	Capacity building workshops at District level	2	Rs. 1.25 Lakhs	Rs. 2.5 Lakhs	B.14.2	50 members batch 2 workshop for 2 days is proposed at District level
Total				Rs. 5.00 Lakhs		

Budget summary for UHC for the year 2014-15

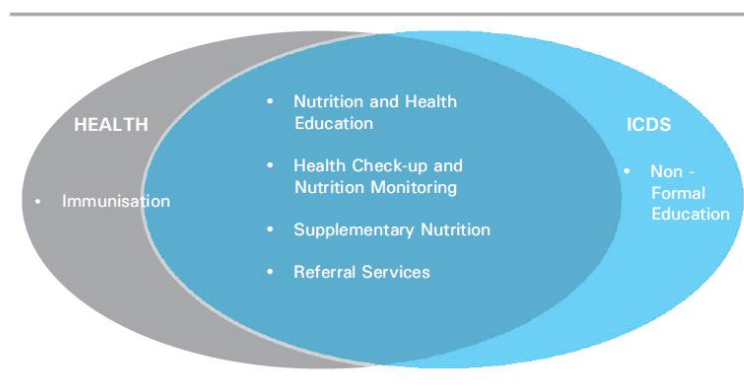
Sl.No	Activity	Total Amount Rs. In lakhs	FMR code	Remarks
1	Advocacy workshops for UHC	Rs. 60.00	B.14.2	
2	Specific studies for UHC	Rs. 30.00		
3	Capacity building	Rs. 5.00		
Total		Rs.95.00		

B.14.1

A brief note on convergence workshops at State and District levels for providing improved maternal, child health and child development & nutritional services in RMNCH+ A Districts, Karnataka.

Situation Analysis and the need for convergence efforts: The key Government Departments which are responsible for maternal and child health are: the Department of Health and Family Welfare (HFW), which implements a number of programmes and initiatives through the public health care system; and the Department of Women and Child Development (DWCD), which implements the world's largest child development and nutrition programme - the Integrated Child Development Services (ICDS). The considerable overlap in core areas of HFW and ICDS programmes requires careful coordination and synergy during planning and delivery in order to maximise efficiency and coverage as well as reduce potential for confusion. However, this is often not achieved.

The Integrated Child Development Scheme (ICDS), launched in 1975, is the world's largest child development and nutrition programme, catering to over 23 million children below the age of six years in India. Its objectives are to provide early childhood education, nutrition and health services. At the grassroots level, ICDS operates through Anganwadi Centres (AWCs), with one AWC catering to around 1,000 people. There are Mini AWCs which caters the population of 500 at identified hamlets. Each of the AWCs is supposed to be staffed by one Anganwadi Worker (AWW) and a helper. An ICDS supervisor supervises the functioning of approximately 20–25 Anganwadi Workers (AWWs) at the ICDS sector level. Research has pointed to a number of key challenges in the delivery of ICDS. ¹A key recommendation to enhance impact has called for a refocusing of activities through greater **convergence with the health sector**. The Department of HFW implements a range of reproductive and child health interventions (including antenatal care, neonatal care, immunisation, and provision of micronutrients) at the primary, secondary and tertiary care levels. The nearest point of contact of the community with the public health system is the Sub Centre. Each Sub Centre caters to a population of approximately 5,000 and is staffed by an Auxiliary Nurse Midwife (ANM). Along with the Medical Officer from Primary Health Centre (PHC), these health workers have to form a team with the ICDS functionaries to achieve convergence of Health and Nutrition services



1. India's undernourished children: a call for reform and action, Health, Nutrition and Population Series, Chapter 3, p. 63, 'Enhancing the Impact of ICDS', Michele Gragnolati, Caryn Bredenkamp, Meera Shekar, Monica Das Gupta, Yi- Kyoun Lee, World Bank, Washington DC, 2006.

New AWCs were established without taking into consideration the jurisdiction of the Sub Centres/Primary Health Centres (PHC), resulting in an overlap in the administrative areas of ICDS and Health. The areas of ICDS supervisors were at times under the jurisdiction of more than one PHC, causing difficulties in oversight with clashing meeting schedules. Similarly, AWCs in the same sub-centre area were at times under the supervision of multiple supervisors. Such issues led to difficulties in planning and coordination between the community-based services of Health and ICDS.

To address this disconnect and improve service delivery, there is a need to initiate a synchronisation process between the ICDS scheme and the Department of HFW focussing on reorganising geographical jurisdictions and collaboratively providing health and nutrition services through the introduction of an initiative to be named as "**MAATHRU CHAAYE**" or "**AMMANA AASARE**" (AA) (The nomenclature is subject to change)

Strategy & Implementation:

Activities:

Sl. No.	Key activities	Details of activities
1	Sub-Centre reorganisation	In order to increase the accessibility of services, existing sub centres need to be reorganised by the Dept.of Health, keeping the proximity and size of the population.
2	Workshop for Micro planning	District level and Taluka level workshops to be conducted for officials from Health and ICDS for planning towards synchronisation; technical advice will be provided by UNICEF. Documentation formats to be designed for planning and monitoring activities.
3	Geographical synchronisation	Boundaries of ICDS sectors needs to be matched with Primary Health Centre (PHC) boundaries to ensure that the ICDS sectors present in one PHC will not overlap with the

		area of another PHC. This ensures that ICDS supervisors are no longer required to visit any AWC outside this jurisdiction.
4	Planning and fine tuning	1. Workshops to be planned to conduct for district and block officials from Health and ICDS to explain guidelines on immunisation, maternal and child health services, growth monitoring activities. 2. Complete the initial phase of micro-planning and finalise geographical synchronisation
5	Planning Mathru Chaaye or Ammana Aasare (AA)	AA will be planned for addressing the health and nutrition needs of the vulnerable rural population. VHN Day will be made as the key driver of this strategy.
6	Scheduling VHN Days	VHN Days will be scheduled in villages, with each session catering to an average population of 1,000 (if the area is less than 500 ppln, will be covered as a hamlet through the services of Mini AWC) micro-planning templates will be drafted (covering details on days, dates, time, locations, roles and responsibilities, logistics and transport)
7	Supervision	On an average, two Supervisors of ICDS and one Female Health Supervisor will be allocated to supervise VHN Day at each PHC. Consequently, it is possible to supervise three VHN Days each week. As 30–36 VHN Days are planned per month, each location needs to be supervised once in three months.
8	Supportive Supervision	Planning will be fine-tuned through joint meetings at various levels to review outcomes, update plans and address impending issues. A template for a sub-centre plan will be prepared. Specific blocks will be assigned to district-level officials to provide supportive supervision and facilitate action to resolve issues. The DC and CEO of ZP will be requested to issue orders to legislatively regroup ICDS and Health to allow this planning to proceed on to the implementation stage.
9	Mobilisation of Beneficiaries	All villages will be asked to complete child-centred micro-planning to highlight issues. Village volunteers will be trained alongside field workers in behaviour change communication. Collaboration with other programmes like RBSK, RKSK, Sarva Shiksha Abhiyan and Total Sanitation Campaigns

Implementation:

Under Ammana Aasare (AA), several health and nutrition interventions will be added to ongoing immunisation sessions on a fixed day and time by Health/ICDS service providers. AA adopts an integrated approach to support healthy

development of babies, children, out of school adolescent girls, pregnant women and lactating mothers. It comprises four components:

VHN Day:

VHN Day is the most critical component of the AA initiative. It occurs every month in each village at existing Anganwadi Centres, Sub Centres, Primary Health Centres or Community Health Centres by Health and ICDS functionaries (one VHN Day is scheduled for an average population of 1,000). Services are provided to all children below five years of age, ante-natal and post natal cases and adolescent girls.

The following maternal health, child health and nutrition services are provided:

Maternal Health:

Early registration of pregnancies, focused antenatal care, referral services for emergency cases, counselling, birth preparedness and promotion of health services.

Nutrition: Weighing of children, growth monitoring and nutrition counselling, checking, advising and referring anaemia cases, Iron and Folic Acid (IFA) tablets to adolescent girls, Iodised salt to pregnant and lactating women up to one year and supplementary nutrition.

Child Health:

Registration of new births, counselling for care of new born, feeding, nutrition, complete immunisation, dosage of vitamin A along with measles vaccine, IFA tablet to children with clinical anaemia, weighing and growth monitoring, organisation of Oral Rehydration Salts depots at the session site and supplementary nutrition.

Ammana Bheti:

Another component of AA is post natal care visits by the Anganwadi Worker (AWW) and/or Auxiliary Nurse Midwife (ANM) in an effort to reduce mortality during the neonatal period. Babies are to be visited three times in the first ten days of their life. If the baby is assessed as low birth weight, then an additional three visits are to be made within the first months for continued follow-up.

Thayi Aaraike

Emphasis has been laid on provision of referral services based on assessment of ANMs or AWWs. These services may be provided by a Child Development and Nutrition Centre, community, Primary Health Centres or the District Hospitals. In case doctors are unavailable, specialist clinics are arranged once a month for referral cases.

Thayi Nondani: (Mother registration)

Pregnant and postnatal women carry their own maternal and child health records, known as the Thayi Card. This allows service providers to have access to accurate growth charts and records of previous interventions. The card has proved to be a good communication tool, equipped with pictorial messages.

Resources/Costs:

Sr. No	Activities	Unit cost	Total Cost.
1	State Level Workshop for Policy decision	300,000	300,000
2	District Level orientation workshops in 8 HPDs	50,000*8 = 400,000	400,000
3	Taluka Level orientation in 42 Talukas in HPDS	10,000*42 = 420,000	420,000
Grand Total			1,120,000

B14.5

Implementing high impact interventions in the high priority districts of northern Karnataka as a part of RMNCH+A call to action strategy

Nurse Mentors Program

Background:

Improving quality of maternal and newborn care within the facilities (delivery points) is critical to achieve the desired outcomes especially in the current context when most of the deliveries are happening in the institutions. This means that the facilities should be equipped with **skilled and confident staff** as well as uninterrupted availability of critical drugs and supplies. Trainings have been successful in raising knowledge of providers, but not adequately the skills and practices. **Ongoing support** both for clinical and non-clinical issues for the staff nurses at the delivery points is a major gap in the current moment. Onsite mentoring program using a cadre of nurse mentors has proven successful in strengthening the clinical and nonclinical skills of staff nurses and the teams to be able to work as a team and deliver high quality maternal and newborn care. There is increasing realization within the government that modalities such as onsite mentoring and supportive supervision should be increasingly adopted to enhance the quality of care.

One other major gap at the community level is the poor capacity of frontline workers and lack of simple and user friendly tools to be able to manage outreach, to communicate key messages to the families, to detect and refer high risk pregnancies to higher facilities for timely care. Here again, the need for **supportive supervision of the front line workers** and provision of effective

tools and techniques is needed. ASHA mentors are available within the system that needs to be empowered with supportive supervision skills in this regard.

Addressing gaps in these two levels of care (facility and community) backed by use of data for coordination, tracking and planning is the third critical gap that needs addressal. While HMIS/MCTS provide the data, the poor quality of data and lack of capacities within the districts to analyse and use the data on a real time basis is missing. This needs to be addressed through appropriate capacity building and use of user friendly software to be able to download data in real time and use it.

Proposed approach and strategies:

Improve quality in the facilities: A dedicated cadre of **nurse mentors** will be trained and designated to a certain number of delivery points in each district. The mentors will visit once in two months to the facilities, spend 3 days to help the staff nurses and other team members in addressing critical gaps related to delivery and postpartum care, supplies, referral and infection control. The high volume facilities will be visited more frequently. The mentors will provide on the job coaching using case demonstrations, models and case studies. A simplified case sheet will be provided to the staff nurses that acts as a job aid, reminds the staff nurse of all the management steps across the sequence of care, help in diagnosing and managing complications promptly; the case sheet is easy to document and can be regularly audited for improving quality. The case sheet is also a teaching aid. The mentor will be initially trained for 4 weeks in a medical institution in the areas of skilled birth as well as mentoring and teaching skills. Later they will be positioned in each block to be able to visit the facilities regularly. They will be supported by a senior nurse mentor who will assist them and supervise in their routine work. The senior mentor will be reporting to the RCHO of the district. Thus the mentors will be working under the direct guidance of the district level officials to be able to support the PHCs. The mentors will also liase with the district training centre and the hospital for their continuing education and clinical refreshers.

Improving the capacities of the frontline workers: The frontline workers specifically ASHAs need simple to use tools to enumerate and track their beneficiaries. The ASHA diary that is a single register that helps ASHA perform many tasks connected to outreach and home visits are found to be useful which has been taken up the government of Karnataka. The ASHA facilitators and ASHA mentors within the systems will be trained in the supportive supervision skills to support ASHAs in using the diary. The technical capacities of the frontline workers will be addressed by the nurse mentor on an ongoing basis. The nurse mentor during her visits to the PHCs, will also make sure that the junior health assistant-female (JHA-F) and the lady health visitor (LHV) are present at the PHCs so that their technical capacities are built who can in turn strengthen the ASHAs and AWWs. Specific focus will be provided around the

issues of screening and timely referral of high risk pregnancies, birth planning and preparedness, appropriate follow up of post partum mothers, etc will be held. This can enable improved quality of service provision at the community level as well as a stronger linkage between community and facilities.

Improving quality of HMIS/ MCTS: The newly recruited M&E specialists need to be trained in several areas such as validating quality of data, analysis and use of data related to HMIS/MCTS. There is a need for a capacity building plan in this regard that address their initial and ongoing needs.

Proposed budget for nurse mentoring program for eight high priority districts(six months):

Budget head/activity	No	unit cost	No of months	Total cost
Nurse mentor salary	42	15000	6	3780000
Senior nurse mentor salary	8	20000	6	960000
Monthly travel	50	3000	6	900000
Training of nurse mentors in 4 batches	3	600000	1	1800000
Review and refreshers(lumpsum)				500000
Contingency cost @ 10%				848889
Over all costs for nurse mentoring in 8 HPDs for six months				8788889
Trainings for ASHA mentors in supportive supervision				
		Unit cost	# days	
Food and accommodation	50	500	14	350000
TA	50	250	14	175000
Training hall	1	2000	14	28000
Resource persons fees	1	5000	14	70000
Training material	50	1000	1	50000
Over all training				673000
Handholding Asha facilitators for 6 months	8	20000	6	960000
				1633000
HMIS/MCTS and M&E				
Food and accommodation	50	500	5	125000
TA	50	250	5	62500
Training hall	1	2000	5	10000
Resource persons fees	1	5000	5	25000
Training material	50	3000	1	150000
Over all training				372500
Field support for 5 days for 6 months	8	10000	6	480000
				852500

Six month budgets for 8 high priority districts (Oct 2014 to Mar 2015)		
Intervention component	8 districts	1 district
Nurse mentoring (includes salaries of mentors, trainings and mentoring visits)	8788889	1098611
FLW support (includes training and handholding costs)	1633000	204125
M&E support (includes training and field support costs)	852500	106563
Total costs	11274389	1409299
Management cost at 10% of total costs	1127439	140930
Overall costs	12401828	1550228

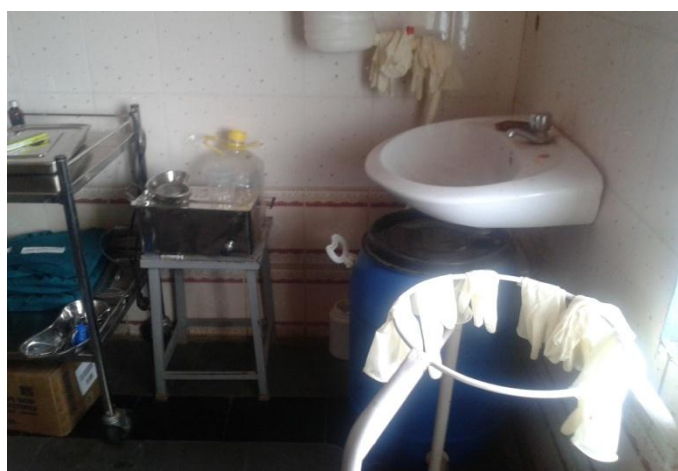
Note: For Frontline worker support and M&E support, we have not budgeted the salaries for ASHA mentors and M&E specialists as they are already a part of the system.

B 14.6

Creating Labor Rooms with Standards - Concept Note Based on GOI MNH Tool Kit Standards

Background:

St. John's Medical College, Bangalore in partnership with UNICEF, undertook the RMNCH+A Gap analysis in High Priority Districts of Karnataka, on request from the Government of Karnataka. The Objective of the Gap Analysis is to rapidly identify the gaps / bottlenecks in the implementation of strategic RMNCH+A interventions across life stages, in high priority districts of Karnataka, to establish a baseline for monitoring the progress of RMNCH+A, to provide inputs for District Health Action Planning, and to develop district- specific strategies and activities to improve RMNCH+A health outcomes. A sample of health facilities across all levels as well as community and households, was surveyed in the district.



Current Situation: The common gap identified across all the districts was the poor condition of the labor room. It was observed that the following were the areas of concern in labor rooms,

- NBCC not functional
- Maintenance of Partographs and KMC protocols,
- Neither 24X7 electricity supply nor generator/UPS back up for the labor room
- Non-availability of separate sterilized delivery kits
- Multitasking of SNs working in Labor Room
- Poor Bio Medical Waste management
- Poor hand washing practices
- Delay in Early Initiation of Breast feeding
- Lack of Monitors in the labor room
- Essential drugs - Inventory management of the emergency drugs with label and a list of drugs not found in the delivery rooms
- Shortage of Inj Oxytocin, Inj Magnesium Sulfate, Tab. Mifepristone etc observed



Strategy:

During the financial year for which the PIP is probed it is planned to create 5 model labor rooms in each of the HPD. The 24*7 PHCs with high volume load and has got recently new building will be taken on priority. The standards as per the GOI MNH Tool Kit will be taken as the yard stick to operationalize the standard labor rooms.

Ten key steps to ensure smooth working in the Labour Room

1. Ensure that the 7 trays are kept arranged and available for use.
2. Equipment needed in the LR are available, in good condition and functional – labour table, BP apparatus, stethoscope, foetoscope/ Doppler, footstep, stool for companion, maintained Partograph.



Taluk Hosp. Sindhanur – Labor Room: No elbow

3. Environment in the LR is conducive – cleanliness, temperature maintained, curtains, windows with intact panes, privacy and attached functional toilet with running water. If the facility has the availability of specialist or trained manpower than keep him informed well in advance specially in high risk cases.

4. NBCC with:
 - a. Radiant warmer plugged in functional and switched on at least half an hour before the time of delivery.
 - b. A pretested and functional newborn resuscitation bag and mask is kept ready on the shelf just below the radiant warmer.
5. Suction apparatus:
 - a. For Newborn: Dee Lees in the tray
 - b. For mother: Foot-operated/electrical suction machine is functional along with disposable suction catheter
6. Oxygen Cylinder: Filled, with key tied on it, new disposable tube is used every time oxygen is given; the oxygen flow is checked under water (in a bowl) before inserting the tube.
7. Hand washing area has soap and running water, long handle tap which can be closed with elbow.
8. Infection Prevention Practices observed; drums to store sterilized items such as gloves, instruments, linen, swabs and gauge pieces. Autoclave exclusive for LR available and functional; delivery instruments are wrapped in a sheet and autoclaved in enough numbers (1 set for each delivery); autoclaving is done at least twice a day (at the end of morning and evening shift); 0.5% chlorine solution prepared freshly every day and soiled items are first put into this before further treatment. Personal protective equipment is used while working in the LR.
9. Waste disposal – Colour-coded bins are available; these are emptied at least once a day or as and when they are full. Liquid waste also to be managed appropriately.
10. Records – Partograph, labour register, refer-in/refer-out registers are available and completed for each case.

Essential Commodities

Wheelchair and/or stretcher Examination table with foot step and curtain for privacy Foetoscope/Doppler Table and chair for doctor BP apparatus with stethoscope Thermometer Wall clock Adult weighing scale Measuring tape Emergency drug tray Hub cutter Puncture proof container Colour coded bins Partograph Cetrimide swabs Disposable gloves	Records/ registers Refrigerators Utility gloves MCP card, safe motherhood booklet IUCD client card Sterilized swabs and instruments Washbasins 0.5% chlorine solution and a tub Examination tray Delivery tray in case of emergency Bucket and kelly's pad IV stand Scissor For communication- telephone facility
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Ideal no. of rooms (exceptions at the PHC)

1. Receiving area
2. Examination room
3. Pre- delivery room (1st stage area)
4. Delivery (labour) rom both septic and aseptic with NBCC (2nd& 3rd stage)
5. Post delivery observation room (4th stage)

Checklist

Pre delivery equipment & accessories:

- Foetoscope/Doppler
- BP apparatus with stethoscope
- Thermometer
- Wall clock
- Color coded bins
- Cetrimide swabs
- Disposable gloves
- Bed head tickets with attached partograph
- Utility gloves
- Washbasin
- I.V. stand
- Sterilized instruments

LABOUR ROOM

Labour table with mattress, sheet, pillow (Numbers as per case load), Macintosh, foot-rest Brass V drape to collect blood and amniotic fluid Wall clock with seconds hand Wall mounted thermometer Suction apparatus Equipment for adult resuscitation Equipment for neonatal resuscitation Delivery trolley IV drip stand Consumables like gloves, apron, cotton thread, gauze, sanitary pads, catguts, IV drip sets, needle, cord clamp, medicines (injectable, oral and parenteral, leucoplast etc Pulse oxymeter Sterilizers Oxygen cylinder Oxygen concentrator Partograph Labeled plastic jars for drugs and injectable with date of expiry written on them against each drug Coloured bins for bio medical waste management Hub cutter	Screen/ partition between two tables Stool for birth companion Lamp- wall mounted or side Autoclave drums for instruments, linen, gloves, cotton, gauge, threads sanitary pads Autoclaved delivery set for each delivery Refrigerator Sphygmom anometer, adult and newborn thermometer and newborn weighing machine Puncture proof containers Plastic tubs for 0.5% chlorine solution Intranatal protocols (AMTSL, PPH, etc.) Wheel chairs/ patient's trolley 7 trays: delivery tray, episiotomy tray, medicine tray, emergency drug tray, baby tray, MVA tray, PPIUCD tray Hand washing area and toilet for the admitted clients Foeto scope/ Foetal Doppler Stethoscope Display of SBA quality protocols and shadow less lamp Mosquito repellents
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Trays to be kept in Labour Room

1. **Delivery tray:** Scissor, Artery forceps, Sponge holding forceps, Speculum, Urinary catheter, Bowl for antiseptic lotion, Kidney tray, Gauze pieces, Cotton swabs, Sanitary pads, Gloves.
2. **Episiotomy tray:** Inj. Xylocaine 2%, 10 ml disposable syringe with needle, Episiotomy scissor, Artery forceps, Allis forceps, Sponge holding forceps, Toothed forceps, Thumb forceps, Kidney tray, Needle holder, Needle (round body and cutting), Chromic catgut no. 0, Gauze pieces, Cotton swabs, Antiseptic lotion, Gloves.
3. **Baby tray:** Two pre-warmed towels/sheets for wrapping the baby (Baby should be received in a pre-warmed towel. Do not use metallic tray.), Mucus extractor, Bag and mask, Sterilized thread/cord clamp, Needle (26gauge) and syringe(1ml.), Inj. Vitamin K, Gloves.
4. **Medicine tray*:** Inj. Oxytocin 10 IU (to be kept in fridge), Inj. Gentamicin, Inj.Vit K, Inj. Betamethason, Inj. Hydralazine, Cap Ampicillin 500 mg, Tab. Metronidazole 400 mg, Tab Paracetamol, Tab Ibuprofen, Tab B complex, Tab.Misoprostol 200 micrograms, Tab.Nifedipine, Tab.Methyldopa, IV fluids - Ringer lactate, Normal Saline, Magnifying glass. **(*-Nevirapin and other HIV drugs only for ICTC and ART Centres)**
5. **Emergency drug tray:**** Inj. Oxytocin (to be kept in fridge), Inj. Magsulf 50%, Inj.Calcium gluconate-10%, Inj. Dexamethasone, Inj. Ampicillin, Inj. Gentamicin, Inj.Metronidazole, Inj. Lignocaine-2%, Inj. Adrenaline, Inj. Hydrocortisone Succinate, Inj.Diazepam, Inj. Pheneraminemaleate, Inj. Carboprost, Inj Pentazocin chloride, Inj.
6. Promethazine, Inj.Betamethasone Inj.Hydralazine, IV fluids- Ringer lactate, normal saline, IV sets with 16-gauge needle at least two, IV Cannula, Vials for blood collection, Syringes and needles, Tab.Nifedipine, Tab.Methyldopa, Suction catheter, Mouth gag. **(** – only for L2, L3 facilities)**
7. **MVA/ EVA tray:** Gloves, Speculum, Anterior vaginal wall retractor, Posterior vaginal wall retractor, Sponge holding forceps, MVA syringe and cannulas, MTP cannulas, Urinary catheter, Small bowl of antiseptic lotion, Sterilized gauze/pads, Cotton swabs, Disposable syringe and needle, Tab.misoprostol.
8. **PPIUCD tray***:** PPIUCD Insertion Forceps, Sym's speculum, Ring forceps or sponge holding forceps, Cu IUCD 380A/ Cu IUCD 375 in a sterile package, Cotton swabs, Betadine solution. **(*** – only for L3 facilities with PPIUCD trained provider)**

Disposable masks, caps and gloves should be available in every labour room for use by service providers and for the birth companion. Similarly, There should be enough number of disposable syringes and needles for injectable drugs

Equipment and accessories needed at NBCC

Baby tray Pediatric stethoscope (preferable to have a neonatal stethoscope) Baby scale Radiant warmer Self-inflating bag and mask–neonatal size (0 and 1) Oxygen hood (neonatal) Laryngoscope and Endotracheal intubation tubes* Two set of pencil batteries	Mucus extractor with suction tube and a foot-operated suction machine NG tubes .Blankets .Two clean and dry towels .Feeding tubes .Empty vials for collecting blood .Alcohol handrub .HLD/sterile gloves .Syringe hub cutter.
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Budget Estimation

Approximate Cost	
Labor room equipments	1.5 lakh
NBCC Equipments	75,000
Renovation (Floor, Wall, Ceiling, electric)	10 lakh
Total	12.25 lakh

Total Budget Requirement = 5 Labor Room in each HPDs*8 HPDs*12.25 Lakhs = **490 Lakhs**

B.15. MONIORING AND EVALUATION

Introduction / Situation Analysis :

The Demography and Evaluation Cell is the focal point in the Health Directorate, which monitors the implementation of HMIS and MCTS across the State.

The physical progress of Health Programmes in general and RCH programmes in Particular are captured through Health Management Information System (HMIS), which is an web based data transfer system of GOI. The Data components of HMIS formats as per the guidelines of GOI are captured from the lowest level i.e., from Sub Centers to District Level Hospitals. Around 12,500 health institutions are regularly uploading the monthly data on the web.

The Mother and Child Tracking System (MCTS), the flagship programme of GOI, was implemented throughout the state from 1st of April 2010. The uploading of MCTS data directly on web portal started from 1st of January 2011. The tracking of individual pregnant women for the services they are due during pregnancy till they deliver the healthy baby, is closely monitored at all levels. The newly born baby is tracked for immunization as per standard immunization schedule.

The GIS in Health is very much useful in decision making, planning and preparing action plans. As of now the latitude, longitude and shape files of all the Health Institutions and its boundaries has been created. This data can be used in web application for public access and also for the departmental administrative review and planning.

Expected Level of Achievement : The Family Welfare programme is being implemented all over India on the basis of Target Free Approach since April 1996. Keeping in mind the shortfalls of Target Free Approach, the Government of India adopts Community Needs Assessment Approach (CNAA) From September 1997. The demand of the Community for quality services would be expected to become the driving force behind the CNAA programme making it a people's programme. The objective of the CNAA is to provide family welfare services to the beneficiaries on need based, client centered, demand driven, high quality integrated services. The target fixed for various family welfare programmes based on CNAA survey by districts is not comparable with the demographic calculations, which needs to be, as per the guidelines of Government of India. Keeping the above inference in mind an attempt has been made, to work out the targets for various family welfare programmes based on Demographic characters.

The Mathematical Model has been developed in the Demography section for the purpose of calculating the Expected Level of Achievement. The mathematical model developed has a two way approach for calculating the

Expected Level of Achievement for various family welfare programmes. The first approach will be calculated based on birth order, and the second approach will be calculated based on Unmet Need. Both combined will give the final figure for individual programme. To make things very easy, first the value will be calculated for 1000 population and then it will be calculated for the whole district. The same model can be used to calculate the target for different health institutions based on the population covered under its jurisdiction.

Evaluation of ongoing and implemented schemes in any department is a must, for effective planning of schemes in the department. It helps in identifying the loop holes and problems faced while implementing the programmes, so that the best strategy can be worked out to implement the scheme in the right direction. Evaluation studies will have a cross-check and cross verification of various developmental schemes implemented. The lower level staff will work with caution and take extra care while implementing the programmes.

OBJECTIVE :

The main objective is to know the programme implementation at input level, process level and output level and also impact of the programme in the community.

Strategies :

- Strengthening of the existing Monitoring and evaluation cell
- Training and capacity building of Health personnel.
- Impact assessment of HMIS and MCTS implementation.
- Strengthening of existing GIS to make it web based.
- Networking of existing HMIS through e-governance.

STRENGTHENING OF M&E / HMIS / MCH TRACKING:

HR for HMIS/MCTS

Continued Activity

The State HMIS/MCTS wing at state level is responsible for training, monitoring of data uploaded on the web portal and validating the state level data uploaded. Demography & Evaluation Cell at State directorate under the Joint director is in charge of this wing. Regular staff posted at the cell is not adequate to handle the huge workload of the wing. To support the officers in charge of the wing, a team of contractual staff is hired. State M&E managers, state coordinators and field coordinators are the contractual staff. They are managing the day to day activities of the HMIS/MCTS tracking for both State and District Level.

In addition to that 1 GIS coordinator and 2 HMIS/MCTS coordinators to the existing team during 2014-15 required.

Achievement:

Sl.No	Designation	Target	Achievement (Apr 13 to Feb 13)	Remarks
State Team				
1	State M&E Manager	2	1	Recruitment of 1 State M & E Managers at State level is in process
1	HMIS State Coordinator	1	1	
2	MCTS State Coordinator	1	1	
3	GIS Coordinator	1	1	
4	HMIS,MCTS & GIS Field Co-ordinators	8	8	
District Team				
1	District M & E Managers	32	14 M & E Managers at district level (recruited during Dec-2014)	Recruitment of 16 district M & E Managers at district level is in process

Justification :

Additional contractual staff both at district and state cell has helped in continuous monitoring the data collected in HMIS portal. This is evident in increase in registration of pregnant women and children in MCTS portal. Hence the activity is planned to be continued for 2014-15.

Funding Proposed:

SI No	Activity	No. of Units	Cost per Unit (in Rs)	Total Cost (Rs. in Lakhs)	FMR Code
State Team					
1	State M & E Manager	1 + 1 New	30000 X 12 months X 1 = 3.60 lakhs 30000 x 9 x 1 = 2.70 lakhs	6.30	A.10.1.11.1 (Proposed under the budget head of HR for SPMU / DPMU as per GoI guidelines)
2	GIS Co-ordinator	1 + 1 New	40000 X 12 months x 1 = 4.80 lakhs 40000 x 6 x 1 = 2.40 lakhs	7.20	
3	HMIS/MCTS Co-ordinator	2	30000 X 12 months X 2 = 7.20 lakhs	7.20	
4	Field Co-ordinator – 2 for each Division)	8	15000 X 12 months	14.40	

District Team					
1	30 (District M & E Managers)	30	25000 X 12 months x14 = 42.00 lakhs 25000 x 9 months x 16 = 36.00 lakhs	78.00	A.10.2.8.1 (Proposed under the budget head of HR for SPMU / DPMU as per GoI guidelines)
TOTAL				113.10	

The newly proposed manpower improves monitoring the HMIS and MCTS activity to the gross root level and implementation of GIS based monitoring system in the State.

B15.3.1.4 Training cum Review meeting for HMIS & MCTS

Continued activity

Training of various officers and staff of Health Institutions on HMIS / MCTS at various levels is an on-going process. The re-orientation training programmes on ELA, HMIS and MCTS are planned every year as there will be change of programme officer at all levels. It is also required to train the M & E Staff at District and Sub-District level on various issues of Demographic profile, and also the Demographic indicators, which will be achieved through these training programmes.

All District Nodal Officers at state level, all District Health & Family Welfare Officers, Reproductive and Child Health Officers, District Programme management officers, Assistant Statistical Officers, District Programme Managers, District Monitoring and Evaluation Managers at district level, Taluk Health Officers, Block Programme Managers, Data Entry Operators at taluk level, and all Administrative Medical Officers, Health Supervisors and ANM's of all Health facilities who are involved in the HMIS/MCTS activities, require re-orientation training.

Hence it is planned to conduct 4 divisional workshops in 4 divisions of the State for intensive review on both HMIS and MCTS programmes.

Achievement:

Out of 4 planned divisional workshops only one was done. Training on fixing of Expected level of Achievement for District level staff was done. Training on uploading of Infrastructure formats in HMIS portal have given to Block programme Managers. The Blocks which are registering pregnant woman and children with worst performance have been identified and intensive training has been given to improve the Pregnant woman and children registration in MCTS. Training on validating the ANM records in MCTS portal has been done. Monthly review of HMIS and MCTS programme was done.

Funding Proposed:

SI No	Activity	No. of Units	Cost per Unit (in Rs)	Total Cost (Rs. in Lakhs)	FMR Code
State Level					
1	4 Regional workshops at each divisions (which includes review and field visit)	4 workshop X 50 participants X 2 days	2,500 per person per day per workshop	10.00	B 15.3.1.4.1
2	2 Training cum Review on HMIS/MCTS will be conducted at State Level in a year	10 officers from State + 150 participants from 30 District (DHO,RCHO, DPMO,DPM, ASO) =160 trainees	160 X 3 days X 300 Rs per person X 2 trainings in a year	2.88	
3	Expected level of achievement at State level	3 participants (RCHO+FWO+ASO) X 30 Districts = 90	90 X 500 per person per day	0.45	
District Level					
1	4 Training cum Review on HMIS/MCTS will be conducted at District Level in a year	5 participant from District + 352 from Block (176X2 participants) =357 trainees	357 X 3 days X 300 Rs per person per day X 4 trainings in a year	12.85	B 15.3.1.4.2
2	Expected level of achievement at District level		25,000 Rs X 30 Districts	7.50	
Block Level					
1	12 Training cum Review on HMIS/MCTS will be conducted at Taluk Level in a year	352 participant from 176 Blocks (THO+BPM) + 2355 participants from PHC + 8871 participants from SC = 11578	11578 X 1 day X 100 Rs per day X 12 trainings in a year	138.93	B 15.3.1.4.3
TOTAL				172.61	
Rupees One Seventy Two Lakh Sixty One thousand only					

Training to all the officers who are involved in HMIS / MCTS activity improves better performance of data collection, analysis and monitoring at grass root level for the programme.

B 15.3.1.5

MOBILITY FOR M & E OFFICERS:

Continued activity

Monitoring and proper implementation of HMIS and MCTS programmes at the field level requires constant supervision and guidance to the supervisory staff at state and district level. The poor performing districts will be visited quite often to correct and monitor the programme. Monitoring has resulted in improvement in HMIS and MCTS reporting.

Funding Proposed:

SI No	Activity	Cost per Unit in Rs.	Total Cost in Lakhs	FMR Code
State Level				
1	State Officers :	10 officers x 60 days / year x Rs 1000 / day	6.00	B 15.3.1.5.1
District Level				
2	District M&E managers	30 District M&E managers x Rs 3000 / month x 12 months	10.80	B 15.3.1.5.2
TOTAL			16.80	
Rupees Sixteen Lakhs eighty thousand only				

Continuous field visits by State officers and District Monitoring and Evaluation Managers improves the data quality of HMIS and MCTS programme.

PRINTING OF HMIS FORMATS:

1) HMIS formats : Continued activity

After introducing the system of uploading the HMIS data from the facility level (Sub Centre level), since August 2010 in the state, HMIS formats are being printed as per the national guidelines to capture HMIS data. During 2013-14, some of the data elements were included additionally and due to rationalization of HMIS formats printing process was delayed. Now the process of printing revised HMIS formats is in process.

Funding Proposed:

SI No	Activity	No. of Units	Unit cost	Total Cost	FMR Code
1	HMIS Formats for all health facilities (DH/SDH/CHC/PHC/SC)	225432- SCs formats 51768 – PHC formats	Rs. 4.30 per	15.00	B 15.3.1.6

		71070 – CHC / SDH / DH formats	format		
	TOTAL				15.00
Rupees Fifteen Lakhs Only					

INCENTIVES TO DATA ENTRY STAFF OF HEALTH INSTITUTIONS

Continued activity

Karnataka has taken lead in creating separate user Ids and Passwords for individual Health Institutions for entering the data on HMIS and MCTS portal. It is felt that instead of availing the services of computer operators in each health institution for HMIS and MCTS data entry, it is better to identify any one of the permanent staff in each health institution and incentivizing (compensating) him/her with nominal amount of Rs.400/- for HMIS and MCTS data entry with following conditionalities.

1. The health facilities should upload the data through their respective user ids.
2. The health facilities should upload the data within 5th of every month.
3. Registration in MCTS portal of the Taluk should be more than 70%.

Funding Proposed:

SI No	Activity	Unit	Cost per Unit in Rs	Total Cost in lakhs	FMR Code
1	Around 3000 data entry points (DH/SDH/CHC/PHC)	3000 data entry points	400 Rs per month X 12 months	144.00	B. 15.3.1.7.1
	TOTAL			144.00	
	Rupees One hundred forty four Lakhs only				

Other :

Continued Activity

1) HMIS Registers :

HMIS Registers are introduced for the health institutions to capture the details of HMIS data on daily basis, the registers are also used at sub-centre level as ANM dairy to monitor the field visits carried out by the health personnel. These Registers can be used as comprehensive registers for HMIS which comprises of daily, monthly and yearly HMIS data and other demographic data of the health institution.

2) Karnataka Health Profile :

Karnataka health profile booklet printed and distributed by the demographic section of the Health department, which will have the information of state and district demographic indicators.

Funding Proposed:

SI No	Activity	No. of Units	Cost per Unit in Rs	Total Cost in lakhs	FMR Code
1	Registers for all health facilities (DH/SDH/CHC/PHC/SC)	30 – DH Registers 146 – SDH Registers 206- CHC Registers 2350 – PHC Registers 8871- SC Registers	130 Rs. Per register	15.00	B 15.3.1.7.2
2	Karnataka Health Profile	4000 Booklets	37.50	1.50	B 15.3.1.7.2
TOTAL				16.50	
Rupees Sixteen Lakh Fifty Thousand Only					

PROVIDING RCH REGISTERS FOR CAPTURING MCTS DATA AS PER GOI GUIDELINES

Continued Activity

B. 15.3.2.1

The Government of India has circulated the RCH registers (version-1.0) which has to be maintained in every sub centre village wise as per the requirement.

The Integrated RCH register is designed for thousand population which would be maintained for two years. Currently as the printing of RCH registers is in process, funding for next year is in process. The fund required for the financial year 2015-16 is Rs. 75.00 lakhs.

PROCUREMENT OF LAPTOPS

New Activity

B 15.3.2.4

To monitor HMIS and MCTS activities in the State, Officers and Staff of demography & evaluation cell have to travel extensively throughout the state, during their field visits to work in HMIS and MCTS portal, Laptops have to be provided to them. Procurement of five Laptops and Multifunctional copier is under process.

To monitor implementation of HMIS and MCTS effectively in districts Monitoring & Evaluation Managers working in 30 districts have to be provided with Laptops.

Funding Proposed:

SI No	No. of Units	No. of Units	Cost per Unit	Total Cost	FMR Code
1	laptops including Operating System, MS office, Antivirus	30 laptops	80,000 per laptop	24.00	B 15.3.2.4
	TOTAL			24.00	
	Rupees Twenty Four Lakhs only				

Providing laptops to the District Monitoring & Evaluation Managers helps in monitoring HMIS and MCTS programme.

ANNUAL MAINTENANCE OF COMPUTERS/ PRINTERS/ UPS

B 15.3.2.5

Continued Activity

The Desk Top Computers used by Officers and Programmers are three to four years old and needs frequent maintenance. The Fax, Multicopier, Local Area Network (LAN) connection was provided to Demography & Evaluation section during the year 2009-2010, which needs frequent maintenance. Annual maintenance for LAN & multifunctional copier has been given.

The 176 Desktops provided to Block Health Office at Blocks requires Annual Maintenance Contract.

Funding Proposed:

SI No	No. of Units	No. of Units	Cost per Unit in Rs.	Total Cost	FMR Code
State Level					
1	Computers	11	4000	0.44	B 15.3.2.5
2	Fax and Multicopier	1	1,00,000	1.0	
Taluk Level					
1	176 Desktops provided to THO office	176	4000	7.04	
TOTAL				8.48	
Rupees Eight Lakhs Forty Eight Thousand Only					

ANNUAL MAINTENANCE OF LAPTOPS

Continued Activity

B 15.3.2.6

The Laptops used by Officers and Programmers are three to four years old and needs frequent maintenance.

The 30 Laptops provided to Assistant Statistical Officer at District Level requires Annual Maintenance Contract.

Funding Proposed:

SI No	No. of Units	No. of Units	Cost per Unit in Rs.	Total Cost	FMR Code
State Level					
1	Laptops	5	4,000 Rs per year	0.20	B 15.3.2.5
District Level					
1	30 Laptops provided to ASOs at District	30	4,000 Rs per year	1.20	B 15.3.2.5
TOTAL				1.40	
Rupees One lakh Forty Thousand Only					

Internet connectivity through LAN / Data card

B 15.3.2.7 (Continued Activity)

Recurring expenditure for internet connection through data cards needs to be constantly procured for smooth functioning of HMIS & MCTS Programmes.

Out of 37 data cards procured, 30 data cards are supplied to Assistant Statistical Officers working in 30 districts and 7 at Head Office. These are very useful as the data being captured in HMIS/ MCTS on a web based system.

Funding Proposed:

Sl No	Activity	No. of Units	Cost per Unit	Total Cost	FMR Code
1	Data Cards	37	Rs. 50,000 per month for 37 data cards	6.0	B 15.3.2.7
TOTAL				6.0	
Rupees Six Lakhs Only					

Mobile Reimbursement (CUG SIMs)

Continued Activity

Mother & Child tracking is expected to facilitate qualitative improvement in delivery of services to pregnant women & children which results in reduction in maternal, infant & child mortality.

After providing CUG sim, service updation for the Pregnant Woman i.e., (ANC1, ANC2, IFA etc.,) and Children has improved by 20%. Mobile usage also helps in capturing real time data and to generate work plans, alert messages to health department personnel and beneficiaries. Intrapersonal communication between the field worker and beneficiaries is made easy.

Validation of the ANM phone numbers achieved upto 95% and phone numbers of ASHA validation started in MCTS portal.

It is quite evident that much of the workload, travel, and time is being saved for ANM due to this mobile technology which is very user friendly. Around 16938 CUG SIMS are provided to staff and officers who are involved in MCTS activities. As per the new tariffs the revised amount of **Rs 250 Lakhs** is required annually to maintain the CUG SIMS distributed.

Funding Proposed:

Sl No	Activity	No. of units	Cost per Unit	Total Cost	FMR Code
1	CUG SIMs for ANMs	16938	Rs. 123/- per SIM X 12	250.00	B 15.3.2.13

			Months		
TOTAL				250.00	
Rupees Two Hundred Fifty Lakhs Only					

As Karnataka is using mobile based SMS technology for updating the service provided to the pregnant woman and children in real time for MCTS application, procurement of CUG SIMs to the ANMs progresses service updation. And also improves the intrapersonal communication between the health workers.

Other : Cartridge for Printers & Stationary items

Recurring expenditure for Cartridges for printers, AntiVirus Software for computers and laptops, paper and stationary items etc..., needs to be constantly procured for smooth functioning of HMIS & MCTS Programmes.

Funding Proposed:

SI No	Activity	No. of Units	Cost per Unit	Total Cost	FMR Code
1	Cartridge for Printers & Stationary items	Cartridges for 5 printers	1.00	1.00	B 15.3.2.14
	TOTAL			1.00	
	Rupees One Lakhs Only				

B. 21. Karnataka State Health Resource Centre

- Year of establishment of SHSRC - It was registered on 2nd March 2009
- The organization chart: number and designation of existing staff along with salary details**

KSHSRC - Present Human Resource Status				
Sl.No	Division	Units	Salary / pm (Rs.)	Remarks
1	Executive Director	1	75,000	As per ROP 2013-14
2	Consultant - Health Economics & Financing	1	50000	
3	Consultant - Monitoring & Evaluation	1	50000	
4	Consultant - Quality improvement & Service delivery	1	50000	
5	Consultant - Public Health Planning	1	50000	
6	Consultant - Human Resources	1	50000	Interview was held on 10th May 2014 for filling the vacancy
7	Consultant -Community processes	1	50000	
8	HMIS Coordinator	1	30000	Interview was held on 10th May 2014 for filling the vacancy
9	Research cum Documentation Officer	1	25000	
10	Data Analysis coordinator	1	20000	
11	Accountant	1	22500	
12	PA to Executive Director	1	15000	
13	Steno cum Computer Operator	1	15000	
14	Group D (Two)	2 (out sourced)	22000	@ Rs. 11,000 per person/month
15	Driver	1 (out sourced)	13228	Approved in other cost B 21.2
16	Security	1 (out sourced)	11000	

Annual work / progress reports for the last two years including key performance outputs:

Physical performance for 2012-13

- Rapid Assessment of Functional SNCUs in Karnataka
- Joint study along with IHMR on study of Assessment of functioning of Male Health Workers in Karnataka
- Computerisation of reports under school health program (SAC)
- Non budgeted activities Study on Duties & Responsibilities
- Examination of Compensation Structure and Training Needs Analysis of Accredited Social Health Activists in Karnataka –A Study Sponsored by Karnataka Jnana Ayoga: Jnana Shodha 2012
- Audited the Accounts for the financial years 2011-12 of KSHSRC.
- External evaluation of Suvarna Arogya Chaitanya School Health Program

- Computerisation of reports under school health program (SAC)
- Evaluation of the process of maternal death review (audit) in Karnataka.
- Four best research awards in the state for the medical officers of the department on subjects relevant to the department.
- Capacity building of the District Project Management officers of the department for optimum monitoring and evaluation function.
- Workshop for District Nodal officers of H&FW on supportive supervision to be conducted
- Workshop for District Project Management officers of all 30 districts on Basics of budgeting of health programs

Physical performance of KSHSRC for the year 2013-14

KSHSRC Workshops

- Workshop for sensitization of the MLA and MLCs in the Belgaum division on the various health programs in the State. The workshops for PRIs of the remaining three divisions will be done in the month of February.
- KSHSRC has developed comprehensive informative book let on the benefit schemes and the programs available in the Health Department for people living below poverty line. This was given as a referral document to all the elected representatives and others including Departmental heads and media to create awareness about the programs of health Department. It is being developed both in Kannada and English.
- KSHSRC has been actively participating in mass media like TV/Radio programs to spread awareness about the health programs for the people.
- State-level workshop to the district officers on planning for District Health Action Plan (DHAP) in association with NHSRC, and facilitating District health action planning across all 30 districts. Thus facilitating State PIP 14-15
- Workshop on Supportive Supervision to the State level Nodal Officers and timely analysis of the Nodal Officer's checklist for review by the Commissioner of the Health department.
- State-level and District-level Workshops on Universal Health Coverage
- KSHSRC has facilitated the AYUSH Department in developing, planning, capacity building, Supportive supervision mechanisms, Organisational structure and implementation of AYUSH Pushsti , a program to improve the nutritional status among the malnourished children in Bagalkote district as a pilot.

KSHSRC activities/studies

- Consultations and deliberations for the DHAP process, dissemination of the formats/templates and guidelines for data collection and coordination of the DHAP activity in the 30 districts
- NUHM - Series of consultations with different stakeholders and consolidation of their inputs to write a roadmap for implementation of NUHM in Bangalore city in Karnataka
- Writing City specific PIPs and facilitating the planning process for NUHM in 4 cities – Bangalore, Mysore, Mangalore, Bagalkot and Ullal town for the year 13-14
- Developing operational guidelines for prevention and management of Non-Communicable Diseases – KHSDRP, a World Bank-funded project

- Immunogram - A Pilot program for Rapid Improvement in Immunization Coverage in Chikballapur district

Public Health Planning

- NUHM planning - Visited the cities chosen for NUHM implementation for assessing their requirements and prepare the plan for the cities as per the need.
- Model DHAP - Conducted series of meetings and deliberations and gathered data for Mandya district and prepared a District Health Action Plan for Mandya which served as a model for the DHAP process
- Developing formats/templates and the underlying guidelines for data gathering at the Household, Village, Sub-centre, PHC, Taluk and District levels for the DHAP process and coordination of the DHAP process in 30 districts

Health Economics & Financing

- Visited the five cities chosen for NUHM implementation for assessing their requirements and prepared the budgets for the 5 cities
- Joint exercise with Institute for Public Health for the Budget Tracking of State Health Expenditures using 20 indicators for the period 2009 to 2012
- Analysis of the State Health Finances by examining the trends in its composition for the period 2009 to 2012
- Conducted a Gap analysis of the Pre-authorization Procedures and Settlement of Claims under the Vajpayee Arogya Shree scheme during the period 2009-2012. The draft report has been submitted to the SAST-VAS.

Community Processes

- Study conducted to analyse the functioning of VHSNCs in the State and identified strategic and operational inputs for strengthening of the VHSNC's in the State. The report has been submitted for suitable action to the State.
- Undertaken field visits to Yadgir and Raichur districts and to Koppal along with the NHSRC team for monitoring the quality of HBNC training to ASHAs and interacted with ASHAs for assessing their knowledge and field application of HBNC. Observations were submitted to the State for further perusal and is in continued discussion with the State level NRHM officers

Monitoring & Evaluation and HMIS

- Cross-sectional study on Prevalence of Risk factors for Hypertension and Diabetes Mellitus among school teachers.
- The KSHSRC was given the responsibility of strengthening the supportive supervision initiatives at district level and give the feedback to the Commissioner, Dept. of H&FW. A workshop was conducted by KSHSRC in collaboration with IIPH for all the nodal officers on 7th and 8th March 2013. A checklist was designed to collect the information on the functioning and report the performances of various health programs. The designated Nodal officers were sent to the districts and were asked to submit a report on monthly basis. The reports received from the districts were analyzed and a feedback reports were sent to the department for further action.
- Analysis of district-wise IMR and MMR on a quarterly basis and presentations in quarterly meetings.

- Identification of gaps in district-wise HMIS data through Monthly/Quarterly/Yearly analysis and presentations in divisional meetings.
- Validation of HMIS data of Mandya district – A component wise analysis of the HMIS data of Mandya district was carried out on a pilot basis in order to identify the gaps and appropriate strategies were adopted for rectifying the gaps through handholding and continued monitoring. Orientation workshop was conducted for DHO, DPMO, Other District Program officers, THOs, PHC Medical officers and other HMIS reporting staff of the district. As a result of this initiative the district officials were able to identify the gaps in HMIS reporting and update the correct information in HMIS.

1.1.1 Community Processes

National Rural Health mission has initiated community processes such as the ASHA program, establishment of Village Health and Sanitation & Nutrition Committee (VHSNCs) in village, Village Health Planning, provision, and management of untied funds to the VHSNC & sub center. ASHA is the key person in enabling these processes. The past few years has shown that ASHA's role in enabling such community processes remains limited because of various factors.

Under Community Monitoring in the state, monitoring and planning Committees have been constituted at each level i.e. Village, PHC, Block and District. State Mentoring Group and State Resource Group have been constituted for the support and guidance of community monitoring initiative, but we need to further strengthen the community monitoring system for value based inputs at all village, PHC, Block & District levels.

In Karnataka, VHSNCs were formed in the year 2008-2009 and trained by the NGOs in the year 2010-2011. Capacity building programs provided in the year 2010-2011 was not immediately followed by follow up trainings.

It is important to note that the Gram Panchayath members have been newly elected in the year 2011. As new VHSNC presidents who came after 2011 have not received any training. Hence, there is a need to train the Presidents of VHSNCs. It was also revealed in the recent cross sectional study conducted by KSHSRC, that there is a need for intensive training of VHSNCs for effective utilization of untied funds.

KSHSRC will collaborate in the capacity building program of the department. It will support the department in the preparation of the training manual and also support in the identification & selection of NGOs and also in implementing capacity building programs through local NGOs. State level NGOs will be the resource persons in training district level resource persons. District level NGOs will facilitate the training programs at the taluk and PHC level.

The following activities will be initiated as part of community processes in coordination with the department of health and family welfare services.

- Planning and monitoring of capacity building programs
- Organizing workshops at state level
- Identification and selection of NGOs

- Provide technical support in creating awareness to community
- Conduct formative evaluation of the SC/PHC/Taluka level ARS activity with random sampling and provide suggestions to the system to enhance the scope for greater community participation
- Formative evaluation of ASHA HBNC training and provide recommendation for further improvement
- Developing Model VHSNCs in selected talukas of 4 districts. A separate proposal for strengthening VHSNCs in 2 PHCs in 4 taluks in Bellary, Hassan, Chitradurga & Belgaum districts is being attached.

NGO Activity & Private Public Partnership (PPP)

The NUHM Framework for implementation encourages community mobilization so as to make health services and facilities accountable to citizens. Community mobilization emphasizes participation of community and elected representatives by increasing awareness. This is needed to enable communities to access health service and to empower communities to seek the available government health services effectively.

The Mission focuses on community mobilization with a scope to collaborate with NGOs for advocacy, capacity building, monitoring and evaluation in order to increase the reach of health services to community.

In Karnataka NGOs have always played the catalytic role in community mobilization. It is proposed to take advantage of the availability of effective grass roots based field NGOs as well as anchor NGOs in order to strengthen community mobilisation. Therefore, NUHM proposes to have an 'Anchor NGO' in all the implementation areas to facilitate community mobilisation. These Anchor NGOs will be supported by field based NGOs called 'Facilitator NGOs'.

3.1.2. Monitoring & Evaluation

In the Governing Body meeting held on March 25, 2013, the Chairman of the EC suggested KSHSRC to strengthen and streamline HMIS in the State. KSHSRC was entrusted to work on analysis of supportive supervision checklist of various districts in the State. Monitoring and Evaluation plays a vital role. Therefore, considering the present Human Resource strength at KSHSRC, it is felt that the technical support team of HMIS at KSHSRC consisting of one M& E Consultant and one HMIS - Coordinator is not adequate to take the multiple tasks required for strengthening the HMIS and M &E.

Considering the above, in the PIP for the year 2014-15 it is felt that, there is a need to further strengthen the M&E Section enabling them to effectively take up the following new initiatives:

- Conducting Evaluation and research activities in the field of M&E.
- Finding out the gaps in HMIS and MCTS and sending the necessary feedbacks on the corrective action to be initiated at the district level and supervise the team entrusted with the above work at district level.
- Analysis and interpretation of the HMIS and MCTS on quarterly, half yearly and annual basis.
- Analysis of HMIS data and preparing the presentations for zonal level (divisional level) review meetings

- Giving the hands on training to the district M&E team for data analysis and finding out the data gaps in HMIS & MCTS.
- GIS Training at the district level and creating awareness on GIS mapping.
- Training the district level team on DHAP Preparation, data triangulation and analysis.
- Information will be made available in the website on various health facilities at district level and its addresses.
- Assisting state society on HMIS & MCTS training.
- Advanced Data updating by using SAS and Excel and training the district level team in SAS and Excel.
- Providing technical support to M&E team of NUHM.
- Assisting the district level team in data collection and extending the benefit NUHM to the identified cities.
- Identification of beneficiaries and extending the benefit various health programs and its effectiveness.
- Monthly analysis of Supportive Supervision checklist and sending the consolidated feedback to the Health Commissioner at State and presenting the consolidated the feedback in the Supportive Supervision Nodal Officers meeting.

3.1.4. Health Economics & Financing

In the past year 2013-14 several exercises, studies and projects were administered at KSHSRC in the field of health economics and financing.

A budget tracking exercise of the state health finances was done in co-ordination with the Institute for Public Health as per the guidelines provided by the NHSRC's budget tracking toolkit. We would be continuing this exercise year by year at SHSRC, such that we provide the government with a clear picture of the trends in fund allocation and its utilization and plan for the future year's budget.

From the current year, KSHSRC intends to do a district-wise quarterly and yearly analysis of the NRHM finances in the State. With the implementation of NUHM, an analysis of the allocation and utilization of the NUHM finances also assumes importance.

We had undertaken a gap analysis in the operating procedures of the Vajpayee Arogya Shree scheme in Karnataka for the period 2009 to 2012 and suggested measures for improving the operationalisation of the scheme. KSHSRC would continue this exercise in the present year for assessing improvements in performance.

Apart from this, we would also undertake the regular yearly research projects and activities in the area of health economics and financing.

3.1.5. Consultant-Quality Assurance

Quality Management systems, refers to the specific organization of a set of processes that lead to the guarantee of quality services.

After recent launch of 'Operational Guidelines for Quality Assurance in Public Health Facilities', there is a need for fast roll-out of the program in all districts of Karnataka. It entails taking various actions at various levels – Advocacy, customization of the check-lists for meeting needs of Districts in attaining Quality Standards, conduct of workshops & seminars, assisting the health

facilities with gap-closure action, and facilitating the certification process at identified health facilities in states.

KSHSRC has initiated the Quality Improvement program in Karnataka. It is proposed to appoint one consultant-QA and one program assistant to strengthen the QA cell in KSHSRC.

<ul style="list-style-type: none"> • The QA cell aimed at providing support for developing quality management systems at hospital levels leading to improvement of services quality and quality certification.
<ul style="list-style-type: none"> • It also helps the State develop and adopt standard protocols for providing quality health care services.
<ul style="list-style-type: none"> • Set of activities to monitor and improve performance, in order to provide safe and efficient patient care.
<ul style="list-style-type: none"> • Evaluation of the structural prerequisites, performance process and ultimately the outcome is carried out systematically to bring about improvements.
<ul style="list-style-type: none"> • Identifying differences between targeted quality and achieved to analyze the underlying causes.

It is also proposed to undertake assessments and monitoring of quality protocols adopted by the State and suggest changes and improvements and provide technical and management guidance for implementing quality protocols.

3.1.7. Public Health Planning

To make the planning process of NHM at State and district level more effective, KSHSRC intends to act as a resource organization for inducing result oriented planning. The outcome of the planning process would be better program designing & improved program management. PHP consultant would be responsible for capacity building and orientation of the teams at State & District levels. At present there is no public health cadre in the department, this lacunae needs to be addressed. To strengthen the existing system we require additional HR & technical support for Public Health Planning. At present the mechanism of preparation of NHM planning, monitoring checklist for Taluka health officers, development of standard operating procedures for planning, designing of formats for assessment of health needs and health status of the community, development and sensitization activities for district planning units has been technically supported by Public health planning division of KSHSRC.

3.1.8 AYUSH PUSHTI program

In the year 2013-14, Government of Karnataka launched innovative program of "Ayush Pushti". The program provides mainly supplementary nutrition to the Anganawadi Children in the form Ayush Pushti Biscuits, which has Ayurvedic ingredients for better growth and developments among 3 to 6 years children. The main expected benefit is to reduce malnutrition in pre-school going children and strategies to prevent under five morbidity and mortality.

KSHSRC being one of the technical partners with the Ayush department has provided support to launch the program in Bagalkot district of Karnataka. Since the program is in pilot project, KSHSRC intends to provide technical support with appoint of one consultant -Ayush Pushti to monitor, provide supportive supervision give technical feedback and conduct mid-term evaluation of the

activity and give recommendations, so that the program can be effectively implemented throughout state based on the feedback of pilot district.

Proposed studies and workshops for the year 2014 – 15

1. Impact of Expenditure on Tribal Health

In Karnataka, there are several tribal communities, among them several being forest-dwelling tribal people. With reservations of funds for the proportions of tribal populations, the health status of this population and the impact of the health spending on the health outcomes of the tribal population assumes important. One of the forest-dwelling tribe, the Soligas inhabits forest areas in Mysore and Chamarajanagar in Karnataka.

Chamarajanagar is classified as a category "C" district by state. The Soliga tribal people mainly inhabit the forests in the BR Hills, MM Hills and Bandipur forest regions in Chamarajanagar. Very little is known on the particular health problems faced by tribal people like the Soligas. The Vivekananda Girijana Kalyana Kendra, BR Hills runs a hospital supported by the central government and has conducted research to show the existence of Sickle-cell Anaemia among the Soliga tribal people. They have also maintained health records of over 2000 tribal people living in and around BR Hills since 1991. Within the government health infrastructure, BR Hills is a sub-centre under the Gumballi PHC of Yelandur taluk. The Gumballi PHC is an NABH-accredited PHC which also maintains over 7000 health records of NCDs (Epilepsy, Mental health, Diabetes and Hypertension). The other sub-centres of Gumballi PHC cater to both tribal and non-tribal populations.

To our knowledge, no study to date has demonstrated the health outcomes of tribal people in a retrospective cohort. No evidence exists to track the health of tribal people after they come in contact with health facilities. A retrospective analysis of these records and the work being done will enable an understanding about the specific problems of tribal people and could contribute to improving the health status of these communities.

Total budget: Rs. 20,00,000

2. Impact of incentive Schemes of Maternal & Child Health

This is to evaluate the impact of JSY, Prasoothi, JSSK and Madilu programs in the population of randomly selected good performing and poor performing districts in the state and their utilization in terms of improvement in the maternal and child health care. The study will be conducted in eight districts, one good, and one poor performing district in each division (Gulbarga, Mysore, Belgaum and Bangalore division) of Karnataka. The expected benefit of the study is to provide recommendations for quality health care services including better incentive distribution system.

Proposed budget 30, 00,000

3. Analysis of factors leading to errors in reporting of HMIS and MCTS in Karnataka

This is a combined activity with support from Demography section of Directorate of Health, Karnataka state and NHSRC. KSHSRC will prepare a set of checklist and questionnaire for the randomly selected data entry points at various levels of facilities to assess their knowledge and practice

regarding entry of HMIS and MCTS data elements. It will be cross verified with the previous quarter data entry status in HMIS web portal. KSHSRC will assess the timeliness, correctness and completeness of data entry at all levels. KSHSRC & State demography cell will assess the knowledge about verification, analysis, and utilization of data in program management among the taluk and district level managers under the coordination of NHSRC. The expected benefit will be to improve the health management information system (HMIS) monitoring at all levels. So that we can expect quality data at HMIS web portal for future planning and monitoring process.

Total proposed budget-Rs.40, 00,000

4. Community-based Sickle Cell Anaemia Programme for tribal people in Chamarajanagar district

Sickle cell disease in the Soligas

Among the several major health problems faced by the Soliga people is Sickle cell disease (SCD). SCD is a type of genetically inherited anaemias that occurs due to a malformation of an important oxygen-carrying molecule in the blood called Haemoglobin. While a large proportion of the population could be carriers of the sickle cell genetic mutation, a smaller proportion acquire two sets of the genetic mutation and hence manifest with the sickle cell disease. SCD results in severe morbidity and early mortality; affected tribal people have been known to succumb to sickle cell crisis in their youth.

Proposed Budget Rs. 5,25,000

5. Analysis of NRHM-funded programmes in AYUSH department.

One of the strategies of NRHM is to mainstream, streamline, and strengthen the Indian systems of medicine. The Indian system of Medicines supported by NRHM is Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homeopathy. Along with this NRHM is also promoting Nature cure & Traditional healers. NRHM has supported for various AYUSH training activities including awareness on Yoga and Naturopathy to State department officials. NRHM has supported for Ksharasutra & Panchakarma therapies in AYUSH facilities including capacity building for AYUSH Doctors & Paramedics. The main purpose is to get best out of the Indian practices in management of patients and to reduce OOP to the patients. Cluster of programmes are been started under AYUSH which includes "AYUSH Pusti" Biscuits, awareness on "Mane maddu" programme etc. KSHSRC intends to assess the Functionality & utilization of the facilities and services in the AYUSH department. This analysis will be done in coordination with the State AYUSH department, to look at the expenditure pattern of NRHM funds for various programmes and strengthening of various facilities under AYUSH, also impact of AYUSH services under NRHM and its utilization pattern by public will be assessed . this activity will be done in coordination with state AYUSH department considering the achievements for past five years.

Total proposed budget Rs. 20, 00,000

Budget

Sl. No.	Particulars	Unit Cost	Units	Months	Amount (in lakhs)	Rationale
A	Salaries					
1	Executive Director	75000	1	12	9.00	
2	Consultant - Public Health Planning	50000	1	12	6.00	Existing position
3	Consultant - Health Care Financing	50000	1	12	6.00	
4	Consultant - Monitoring & Evaluation	50000	1	12	6.00	
5	Consultant - Quality Monitoring & Service delivery	50000	1	12	6.00	
6	Consultant - Human Resources	50000	1	12	6.00	
7	Consultant - Community processes	50000	1	12	6.00	
8	HMIS Co-ordinator	30000	1	12	3.60	
9	Research cum Documentation Officer-1	25000	1	12	3.00	
10	Accountant	20000	1	12	1.80	
11	PA to Executive Director	15000	1	12	1.80	
12	Data Analysis Coordinator	15000	1	12	1.80	
13	Computer Operator(PA - section)	15000	1	12	1.80	
14	Group D (Two)	11000	2	12	2.64	
15	Security	11000	1	12	1.32	
16	Driver (One Out sourced)	13228	1	12	1.59	
	Total				64.35	
B	Operational Expenses					
1	Vehicles	30,000	2	12	3.60	
2	Mobile reimbursement	1,000	10	12	0.12	1000/Month*30 Persons

3	Internet Data Card	1500	10	12	0.18	(1500/Month*20 Persons)
1	Utilities(Electricity + Water supply)	25,000		12	3.00	
2	Stationery	50,000		12	6.00	
3	EC Meetings	10,000		6	0.60	
4	Governing Body meetings	25,000		2	0.50	
5	Auditors Fees	50,000		1	0.50	Once in a year
6	Telephone Expense	3,500		12	0.42	Landline BSNL connection
	Total				14.92	
D	Travel Expenses					
1	Within State	7500	10	12	0.90	7500/month*20 persons
2	Out of State	25000	10	5	1.25	25000/visit*20 persons
	Total				2.15	
E	Technical Activities					
1	Impact of Expenditure on Tribal Health				20.00	With reservations of funds to improve the health conditions in tribal areas Various innovative and incentive schemes were planned both from state and NRHM budget. This evaluation will help to find or analyses the impact of exp. On tribal health
2	Impact of Incentive Schemes of Maternal & Child Health				30.00	
3	Analysis of factors leading to errors in reporting of HMIS and MCTS in Karnataka				40.00	A combined activity with support from Demography section of State directorate and NHSRC.

4	Analysis of NRHM-funded programmes in AYUSH department				20.00	One of the strategies of NRHM is to streamline and strengthen the Indian system of Medicine. To look at the expenditure pattern and its impact through NRHM in AYUSH department past five years.
5	Community-based Sickle Cell Anaemia Programme for tribal people in Chamarajanagar district				5.25	Community-based Sickle Cell Anaemia Programme for tribal people in Chamarajanagar district
	Total				115.25	
	Grand Total				196.85	

C. IMMUNIZATION PROGRAMME

INTRODUCTION:-

Immunization is one of the most cost effective public health interventions to reduce mortality and morbidity due to vaccine preventable diseases. The expanded program of immunization which was introduced in 1978 mainly focused on Diphtheria, Tetanus, Pertussis, Polio, Measles and childhood tuberculosis. The UIP in 1985 brought in extensiveness and quality to the program. The Hepatitis-B vaccination was started as a pilot program in the state during 2008-09. The JE vaccine as a mass immunization program for 1-5 years children was implemented in Chitradurga, Davanagere (J.E Campaign was implemented in November 2013), Bellary, Kolar, Chickaballpur, Raichur, Mandya, Koppal, Bijapur and Dharwad and now the JE vaccine is included in RI in selected districts of the State. From April 2014 JE programme will be implemented in Chitradurga & Davangere districts. The year of 2012-13 is celebrated as IRI strategy and it is continued in the State. Pentavalent Vaccination was launched in March 2014 and this year has been celebrated as Immunization year in the state with the goal to achieve 100% immunization.

During the preparation of PIP proposals gap analysis was done in high focused districts and low performing districts. All districts have prepared the micro plan to carry out sessions at the field and facility level. The District immunization officer will regularly conduct monthly meeting to address any short fall and to bridge the gap (C.1.a). The HMIS data will be used for situation analysis and for preparing micro plan (C.1.b). The services of ASHA will be utilized to bring children and pregnant woman for immunization and for ANC clinic.

The AVD system will be utilized to supply vaccines and other logistics to session site for better immunization services. We are maintaining good cold chain system in the state and most of the cold chain handlers have been trained for efficient management of vaccines and to reduce wastage. In addition to Dy. Director (Imm) at state level, we have one cold chain officer to take care of vaccines and logistics and **11** Refrigerator mechanics at district level and **6** departmental technicians for efficient management of cold chain equipments. All walk in coolers and freezers are in working condition with sufficient number of ILR and DF. A workshop was held during August 2013 at state level to take up repair of ILR/DF/ voltage stabilizers to control breakdown rate.

Goal:

- To ensure 100% immunization of all eligible children and pregnant woman with required vaccines following standard practices.
- To sustain zero polio status.

Objectives:

- To prevent the incidence of vaccine preventable diseases.
- To prevent morbidity & Mortality due to V.P.D.
- To Achieve more than 90% fully immunization of children under 2 years.

Strategies:

- New born Vaccine Protocol at delivery points.
- Line listening of children from 0 - 2 years.
- Fixed day R.I sessions at PHC & outreach sessions at sub-centers.
- Daily R.I sessions at CHC/Block Hospital/District Hospital/medical Colleges.
- NID for Polio Eradication.
- Establishment of Polio Vaccination booths at district HQ & International airport to prevent importation of polio from endemic country.
- JE Campaign in endemic districts.
- Implementation of S.I.W Weeks.
- Immunogram for HPDs for Rapid back log coverage of DPT & OPV – B & MCV2, JE2.
- Implementation of Vaccine flow chart to monitor supply & distribution of Vaccines.
- Supportive Supervision of R.I Sessions by Immunization field Voluntaries & Medical Collages faculties (10 Collages)
- Monitoring & Evaluation by partner agency (WHO, NPSP)
- Capacity building & training of front line field workers & health personnel.
- Ensuring functional cold chain status at all level.

Achievements:

- Karnataka is Polio Free since 2004 (Indigenous cases), & 2007 from imported case of U.P.
- Sustaining 90% Fully Immunization Children under 1 year.
- Smooth transition of Pentavalant vaccine introduction in place of DPT & Hep-B as one injection.
- Introduction of JE 2nd dose in selected 8 endemic districts.

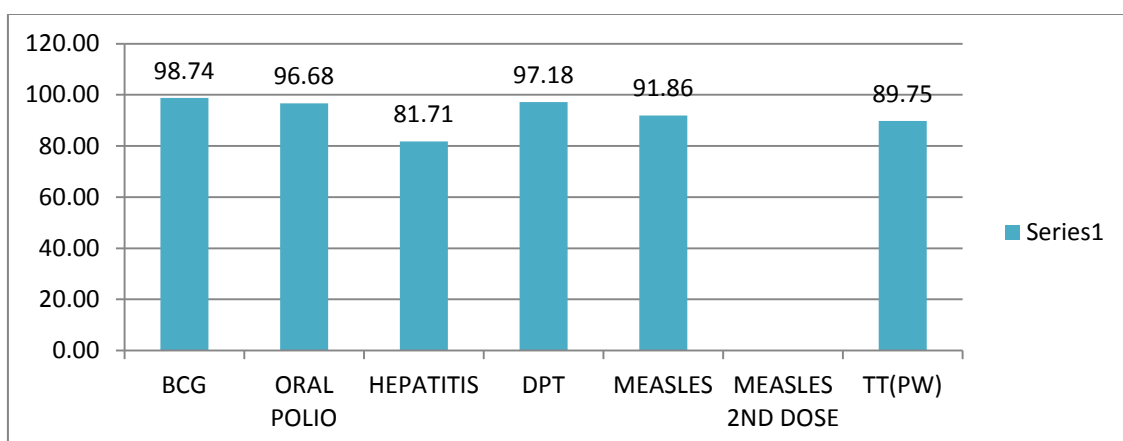
% of children fully immunized (12 to 23 months)

Source	Urban		Rural		Total	
	India	Karnataka	India	Karnataka	India	Karnataka
NFHS-I	51	58	31	50	36	52
NFHS-II	61	59	37	60	42	60
NFHS-III	58	60	39	52	44	55
CES 2009					61.0	78.0

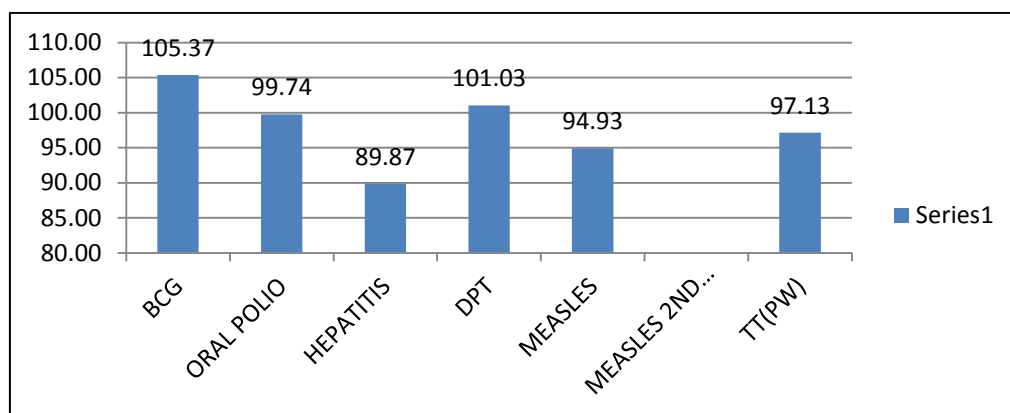
Trends in vaccination coverage - Karnataka

Source	BCG	POLIO-3	DPT-3	MEASLES	Total
NFHS-I	82	71	71	55	52
NFHS-II	85	78	75	67	60
NFHS-III	88	74	74	72	55
CES 2009	-	-	88.2	89.9	78.0

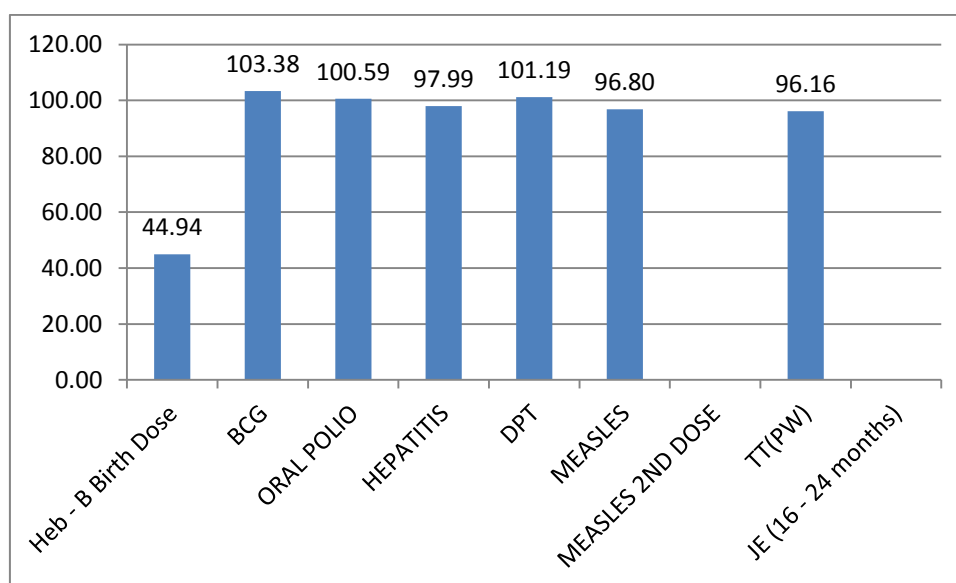
Progress for the year 2010-11



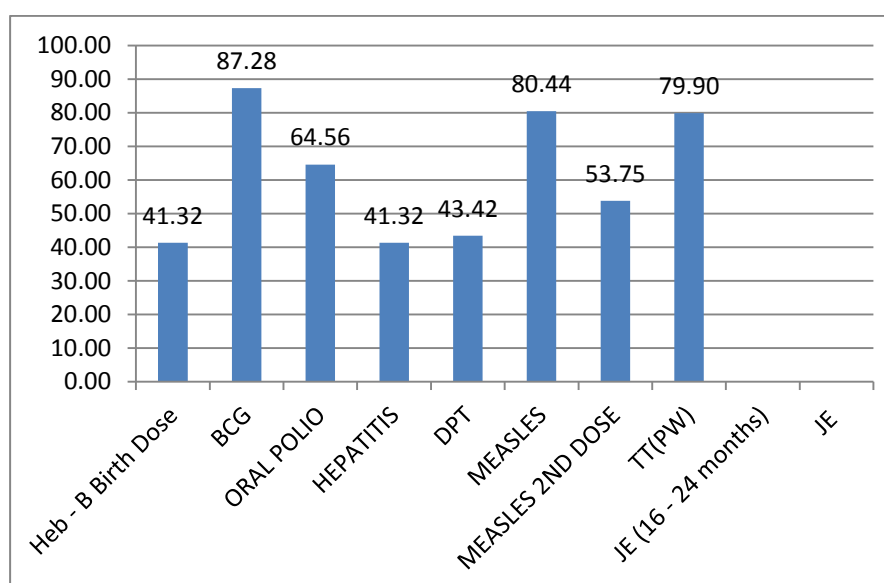
Progress for the year 2011-12



Progress for the year 2012-13



Progress for the year 2013-14



Activities proposed for 2014-15 :

C.1:- Routine Immunization Strengthening Project (Review meetings, mobility support, Outreach services etc).

C.1.a:-Mobility Support for supervision for district level officers. This is a continued activity:To Monitor the Immunization Program mobility support is provided to the following officers.

- 30 Nodal officers visiting the districts every month for supervision of routine immunization as per check list
- At district level DIOs and other program officers who are monitoring the sessions as per GOI issued check list.
- Taluka level THOs who are monitoring RI program.

Achievements:

District Immunization Officer called as Reproductive & Child Health Officer (RCHO) in Karnataka. They implement, plan, supervise and tour the district for monitoring the program. They are provided with funds towards their mobility support. Guidelines have been issued to all DIOs to monitor the sessions as per GOI issued monitoring formats. They are further analyzed at state level by State RI task force under the chairmanship of Principal Secretary, Health and family Welfare department. All 30 District Immunization Officers (DIOs) are continuously monitoring the program by extensively touring the district. The total expenditure for the year 2013-14 is 9.62 lakhs.

Justification:

Mobility support is required for District Immunization Officers to Monitor R.I. Sessions and attend all review meetings at Block and PHC levels (if necessary), and for supportive supervision. Hence this activity continued.

Deliverables:

It is proposed to provide Mobility Support DIOs, Nodal Officers, Medical Officers & Taluka Health officer in all the districts

Funding proposed:

Sl. No.	Activity	No of Units	Cost per Unit (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
1	Mobility support for districts	30	75,000/-	22.50	C.1.a	Rs.75,000 per district *30 this is used for POL & maintenance of vehicle

C.1.b:- Mobility Support for supervision at State level:

This is a new activity

Justification:

For verification of RI Monitoring & NID Monitoring, AEFI & AFP Surveillance & Review Meetings of the Districts, mobility is required for the State level Immunization officer. Hence this activity is proposed.

Deliverables:

To improve RI Program & make every child FIC, AEFI and AFP reporting in the state and quality supervision in the state.

Funding proposed:

Sl. No.	Activity	No of Units	Cost per Unit (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
1	Mobility support at state	1	50,000/-	6.00	C.1.b	Rs.50,000*12 Months (New Activity)

C.1.c Printing & dissemination of Immunization cards, tally sheets, monitoring Forms etc.

This is a continued activity

The immunization programme is conducted at facility level and community level and immunization cards are issued to the beneficiary with details of immunization. At each sessions tally sheets are maintained. The monitoring formats are required to monitor the programme at all level.

Achievements:

The total expenditure for the year 2013-14 is Rs.19.56 lakhs.

Justification:

To keep record of every individual beneficiary and to conduct the sessions in a proper way, immunization cards, tally sheets & monitoring forms are required. Hence this activity is proposed for continuation.

Deliverables:

It is planned to maintain the various records of immunization for programme implementation and this will ensure the uniformity and accuracy of record maintenance.

Funding proposed:

Sl. No.	Activity	No of Units	Cost per Unit (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
1	Printing & dissemination of Immunization cards, tally sheets, monitoring Forms& immunization register etc.	800000	10/-	80.00	C.1.c	New Guidelines says Rs.10 per Beneficiary, total beneficiary are 8 lakhs * 10 = 80 Lakhs

C.1.d:- Support for quarterly State level review meetings of district officers:

This is a continued activity:

The review meetings is done quarterly once at state and district level to review the RI coverage and supervision.

The following meetings are conducted at various levels.

- State level core group committee is headed by Principal secretary, Department of Health and family welfare department
- Quarterly core group meetings are being conducted for review of routine immunization.
- District Health and family welfare officers review meetings are conducted at state level for review of immunization program under the chairmanship of Mission Director (NRHM).
- Separate review of poor performance districts.

Achievements:

During the FY 2013-14, one state level core meeting and 4 divisional level meetings and 5 meetings are conducted and reviewed at high priority districts.

Justification:

Monitoring of the programme implementation at various levels is a key strategy to achieve the desired goal. Review meeting is one of the monitoring activities at state level and district level, hence there is a necessity for continuation of this activity.

Deliverables:

To ensure strengthen of R.I. activity / SIA / micro planning and synchronization of HRAs in R.I. micro plan at periodic levels and promote quality immunization session at all levels.

Funding proposed:

Sl. No.	Activity	No of Units	Unit Cost (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
1	Support for quarterly State level review meetings of district officers:	4	75,000/-	3.00	C.1.d	75,000/- per meeting* 4 Qtrsreview meetings division wise / State
Total				3.00		

C.1.e:- Quarterly review meetings exclusive for RI at district level with one Block MOs, CDPO, & other stake holders:

This is a continued activity

Quarterly review meetings are conducted at district levels & taluk levels by involving all the programme officers, THOs, CDPOs, MOs and other stake holders concerned in all the 30 districts of Karnataka.

Justification:

Monitoring of the programme implementation at various levels is a key strategy to achieve the desired goal. Review meeting is one of the monitoring activity at district & block level, hence there is a necessity for continuation of this activity.

Deliverables:

It is proposed to conduct at least 4 quarterly review meetings in each district to review the RI programme. Updating of the skills and knowledge, effective implementation of RI sessions.

Funding proposed:

Sl. No.	Activity	No of Units	Cost per Unit (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
1	District level meetings	30*4 =120	20,000/-	24.00	C.1.e	30 DIST*4Qrtr = 120 meetings

C.1.g:- Focus on slum & underserved areas in urban areas/alternative vaccinator for slums:
This is a continued activity:

It is planned to conduct the immunization sessions in the underserved areas and slum areas of urban population for every 2500 population. Has there are no ANMs sanctioned in the majority of the urban areas, students from nursing colleges, NGO members and retired ANMs are involved to conduct

outreach sessions in the urban area. The persons involved in conducting immunization sessions are trained by the concerned district RCHO and DHO.

Justification:

In order to reduce the dropout rates and to achieve the 100% coverage of immunization, it is necessary to have outreach activities in the underserved and slum areas of urban population. Hence this activity is continued.

Deliverables:

It is expected to conduct 24000 sessions in the urban slum and underserved areas @ of Rs.525/- per session.

Funding proposed:

No of Units (sessions)	Cost perUnit/session(In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
24,000	525	126.00	C.1.g	There are areas who are not coveredby ANMs in big urban areas

C.1.h:- Mobilization of children through ASHA or other mobilizers: This is a continued activity

In Karnataka totally 30175 ASHAs are trained and they are working in the field. These ASHAs are motivated to bring the dropout children to the planned immunization sessions.They are also involved in immunization programs. These ASHAs will arrange sessions at the village level in co-ordination with AWW and self-help group and create awareness about immunization. The volunteer for social mobilization will be paid Rs.150/- per session for the activity.

Achievement:

The expenditure for the year 2013-14 is Rs.328.53 lakhs and total beneficiaries covered are 2,22,534.

Justification:

In order to bring down the dropout rate and achieve the 100 % coverage for immunization it is necessary to continue the activity.

Deliverables:

Dropout children under 0-5 year age will be immunized as per National Immunization Schedule in Karnataka.

Funding proposed:

No of Units	Cost per Unit (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
280000	150	420.00	C.1.h	280000 sessions * 150(100+50)

C.1.m:-POL for vaccine delivery from State to district and from district to PHC/CHCs: This is continued activity:

Vaccines from state to district and district to peripheral institution have to be supplied at regular interval throughout the year. The vaccine transportation vehicles are available in all the districts and also at the state level, but they require POL and maintenance cost at state level and district level.

Achievements:

The vaccines are transported monthly from state to districts and from district to peripheral institutions like PHCs, CHCs, TLH and DHs. The total expenditure for the year 2013-14 is Rs.20.16 lakhs.

Justification:

Routine immunization is regular programme implemented and vaccine has to be transported from state to districts and from district to peripheral institutions regularly. Hence there is need to continue this activity.

Deliverables:

All vaccines are delivered at respective districts, blocks & PHCs.

Funding proposed:

No of Units	Cost per Unit (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
30	1.5 lakhs	45.00	C.1.m	15,000*30 district

C.1.r:- State specific requirement (Immunization Field Volunteers): This is a continued activity

To strengthen the RI programme and to support the RCHOs in the districts 41 Immunization field volunteers are appointed in all the districts. These volunteers at the district level are coordinating the programme at various levels and they will assist in RI micro plan preparation, VPD surveillance and NID monitoring. IFVs are monitoring about 4 RI sessions and they will visit house to house in 4-5 villages in a week and 3-4 PHC/CHCs in a month.

IFVs are assisting RCHOs in consolidation of all micro-plans from planning units, sample field validate HRAs for SIAs, strengthen surveillance network by visiting 20-30 reporting sites every month. And also assisting RCH officers in tracking timely investigation of AFP cases, sample collecting and shipment of stool samples. IFVs are support measles outbreak preliminary search and outbreak investigation.

Achievements:

38 IFVs are appointed in all the 30 districts of Karnataka and they are trained in routine immunization programme at the state level. The total expenditure for the year 2013-14 is Rs.15.92 lakhs.

Justification:

In order to support the RI programme in planning, implementation and monitoring, additional support staff is required to the RCHOs at the district levels. Hence this activity is continued.

Deliverables:

41 Immunization Field Volunteers (IFV) are appointed out of that 38 are working, since January 2014 in all the 30 districts and they are working in their districts to improve the Routine Immunization (RI) works and to support RCH Officers in strengthening the Routine Immunization, VIP surveillance and polio eradication.

Funding proposed:

No of Units	Cost per Unit (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
41	19200/-	94.46	C.1.r	Rs.19200*41 IFVs*12 Months
41	500/-	2.46		Rs.500*41 IFVs*12 Months (for CUG charges)
Total		96.92		

C.1.v:-Others :- Automatic Temperature data Loggers in 5 districts Pilot project : This is new activity

To achieve real time monitoring of cold chain of all vaccines remotely from State/ District/Block

Justification:

Now it is not possible to monitor real time cold chain except personally going physically to the cold chain point.

Deliverables:

Under this Activity we are able to give Potent vaccines to beneficiaries. Avoid damage the costly vaccines. Get warning message to cold chain handler immediately sitting at adjacent place or away from the cold chain point.

Funding proposed:

No of Units	Cost per Unit (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
5	2,65,000	13.25	C.1.v	Temperature Loggers Device including mobile connection
5	40,000	2.02		One time training and installations
5	45,000	2.25		SMS Plan for each logger (per unit/month)
5	18,000	0.90		Website maintenance cost (per month/unit)
5	36,000	1.80		Technical Support
5	54,000	2.70		Salary (3 person for 150 units)
5	4200	0.21		Mobile Reimbursement
5	10,000	0.25		Computers, printers, internet
5	2,400	0.12		Office and consumables
	Total	24.00		

C.2:-Salary of Contractual Staffs:

C.2.2:-Computer assistants support for district level: This is a continued activity:

One computer assistant is provided for RCH officer exclusively for immunization purpose. He/She will be responsible for collecting reports/ data from taluk level and compile, store and analyze the data at district level and maintain computer data base of all indicators related to immunization. RIMS software will be used for this purpose.

Achievements:

In all the 30 districts Computer assistants are working

Justification:

In order to provide support to the RCHO and maintain the data base of the immunization programme it is necessary to continue the activity.

Deliverables:

Maintenance of quality data, records, analysis reports etc.

Funding proposed:

No of Units	Unit Cost (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
30	15,000/-	54.00	C.2.2	Rs.15,000 * 30 district*12 months

C.2.3:-Others (service delivery staff): This is a new activity.

There is no dedicated staff for transport vaccine - to collect, supply, lift vaccine receive by GoI & dispatch to divisional vaccine store / for supply to the districts.

It is very important to have a trained independent staff for vaccine transportation at various levels in order to maintain the supply of quality vaccines to the health facilities.

Justification:

There is no dedicated manpower to receive, supply and transport at state/district level HQs in order to achieve safety of vaccines and better quality of transport vaccines. Hence this activity is proposed.

Deliverables:

Proper maintenance of cold chain for vaccine delivery from the site of receipt to the site of delivery. It is proposed to have 2 at state and 36 at district level supportive staff (Group-d) and 36 pharmacist for vaccine stores at district.

Funding proposed:

Sl. No.	Activity	No of Units	Unit Cost (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
1	Support staff at state and district level (Group-d)	39	7,000/-	16.38	C.2.3	2 at state level & 23 districts & 14 at 7 state vaccine

						centers* 6
2	pharmacist for vaccine stores	38	11,000/-	25.08		(23+7 SVS * 2 = 14) + 1 for State * 6
Total				41.46		

C.3.1:- District level orientation training including Hep-B, & JE (wherever required) for 2 days ANM, multipurpose Health Worker (Male), LHV, Health Assistant (Male/Female), Nurse Midwives, BEEs & other staff (as per RCH norms: This is a continued activity

Achievements:

2 days orientation training has been conducted in all 30 districts totally 78 trainings are conducted and the expenditure is Rs. 13,03,346/-.

Justification:

Every year refresher training is needed for new and transferred frontline field staffs. Hence this activity is continued and proposed.

Deliverables:

To provide quality and immunization services at facility and community level.

Funding proposed:

No of Units	Unit Cost (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
30 (176)	1,00,000	30.00	C.3.1	Rs. 1 lakh * 30 districts

C.3.2:- Three days training including Hep-B, Measles & JE (Wherever required) of Medical Officers of RI using revised MO training module):

This is a continued activity

Achievements:

3 training sessions are conducted during the year 2013-14 and the expenditure is Rs.2.67 lakhs. In this training programme one day refresher training is conducted for MOs with a revised training module.

Justification:

Every year rigorous and refresh trainings are organized to the MOs to update their knowledge with recent revised modules. Hence it is proposed to continue the activity.

Deliverables: To deliver high quality refresher trainings to the MOs

Funding proposed:

No of Units	Unit Cost (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
30	30,000/-	9.00	C.3.2	Rs. 30,000/-*30 districts

C.3.3:- One day refresher training of district computer assistants on HIMS & Immunization format: This is a continued activity

In order to update the knowledge the computer assistants on RIMS and HMIS refresher training is proposed for the year 2014-15.

Achievements:

3 one day refresher trainings are conducted during the year 2013-14.

Justification:

Refresher training is needed for the computer assistant for updating their knowledge and skills specially on RIMS and HMIS and reporting formats. Hence this activity is proposed.

Deliverables:

Quality data entry, updating immunization formats and timely information collection, compilation and reporting.

Funding proposed:

No of Units	Cost per Unit (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
32	3000	0.96	C.3.3	Rs.3000*30 districts + 2 state Training cost includes training expenditure TA/DA to the participants and other logistic support

C.3.4:-Two days cold chain handlers training for block level cold chain handlers by state and district cold chain officers:This is a continued activity**Achievements:**

Totally 4 trainings are conducted for cold chain handlers at divisional level and the expenditure is Rs.2.47 lakhs

Justification:

Refresher training is provided for cold chain handlers in order to maintain the cold chain properly so that vaccine potency can be maintained. Hence this activity is proposed and continued

Deliverables:

Proper maintenance of the cold chain equipments, quality transportation of vaccines and high standard immunization sessions for beneficiaries.

Funding proposed:

No of Units	Unit Cost (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
176	3000/-	5.00	C.3.4	Rs. 3000* 176

C.4:-Cold Chain Maintenance: This is a continued activity

The state is having functional ILR (Large) -333, ILR (Small) - 2691, DF (Large) - 274, DF (Small) - 2418.

We have eight walk in coolers and three walk in Freezers which are under annual maintenance contract with zero percent break down rate for the entire year. We have received five new walk in coolers and one walk in freezer as a replacement which are being made operational. The cold chain equipments like ILR, DF at district level are being maintained by the refrigerator mechanic whose services are being outsourced under NRHM. In districts where Refrigerator mechanic is not available the equipments are being maintained by other technicians who have been trained in maintenance of ILR/DF. The Breakdown rate in the state for ILR is 3.0 and for DF is 2.6 which slightly above then the specified BR of 2. In coming year the Breakdown rate will be controlled and brought within the specified rate.

Justification:

Preventive maintenance of cold chain equipments is needed to maintain the Breakdown rate as specified in the norms. Hence this activity is continued.

Deliverables: Efficient cold chain maintenance in order to maintain the potency of the vaccines.

Funding proposed:

No of Units	Cost per Unit (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
2787	750/-	21.00	C.4	Rs.750 * 2787 CC Points in 30 Dists

C.5:-ASHA incentive for full Immunization: This is a continued activity:

ASHA incentive is paid @ Rs.100 per child for full immunization in first year + Rs.50 per child for ensuring complete immunization up to 2nd year of age.

Justification:

ASHA incentives is paid to mobilize the children and parents to the vaccine sites and also to reduce to drop out rates. Hence this activity is continued.

Deliverables:High coverage of RI and reduction in the dropout rate.

Funding proposed:

No of Units	Unit Cost (In Rs.)	Total Cost (In Lakhs)	FMR Code	Remarks
4 Lakhs	150/-	600.00	C.5	Rs. 100+50* 4 lakhs

C.6:-Pulse Polio Operational Cost (Tentative):This is a continued activity,

Achievements: 2013-14

1st Round - 7482018 (99.85)
2nd Round - 7516494(100.31)

Justification:

Reduce number of supervisor budget for house to house activity and convert it into increased booths budget. Please add additional 3000 booths,& release separate budget for transit / mobile teams, increase number of booths in Hilly, Ghat, Tribal, Lambani, Thanda areas.Because of hard areas and socially isolated areas.

Deliverables:To sustain and remain **POLIO FREE.INDIA.**

Funding proposed:

Rs.1200.00 lakhs

D National Iodine Deficiency Disorder Control Programme(NIDDCP)

(100% Centrally Sponsored Scheme):

National Iodine Deficiency Disorder Control Programme was implemented in the State since 1988-89, in order to prevent Iodine Deficiency Disorders(IDD) like Cretinism, Deaf Mutism, Dumbness, Physical and Mental Retardation, Goiter, etc among population. This programme is being continued for 2014-15 also.

Iodine is an essential micronutrient, which is required for regulating Thyroid Hormone in human body. Iodine is very essential for normal growth, development and functioning of both brain and body.

Dakshina Kannada, Udupi, Uttara Kannada, Kodagu, Chikamagalur, Chamarajnagar and some places of Shimoga and Mysore are known to be endemic districts.

Objectives:

- To create awareness at the community level about the Iodine Deficiency Disorders and the ways to prevent it.
- To motivate the community to use only iodised salt in daily diet.
- To sensitise elected representatives and Grama Panchayats about Iodine Deficiency Disorder and to take necessary actions about use of iodised salt in daily diet by the community.

Activities planned:

1. Strengthening of IDD cell:

Staff pattern of NIDDCP comprises of establishment of IDD control cell consisting of

Technical Officer – 1

Statistical Officer – 1

Lower Division Clerk – 1

State IDD Laboratory consisting of

Lab Technician – 1

Lab Assistant – 1

1 additional lab technician and lab assistant is proposed

Hence, budget is proposed for salary component of the staff personnel.

- ##### **2. Health Education and Publicity**
- is carried out to promote consumption of adequately iodated salt. Global Iodine Deficiency Disorder week is observed between 21st to 27th October to create awareness about usage of iodated salt. Funds are released to all districts to observe Global IDD Day and Week and to carry out several awareness creating activities as per GOI guidelines.

- 3. IDD Surveys / Re-surveys** are taken up by community medicine department of Medical Colleges to examine the prevalence of Goitre and UIE among school students in the age group of (6-12 years) and estimation of Iodine Content to salt samples at community level.

As per letter No.T.19011/2/2014-Nut & IDD, Nirman Bhavan, New Delhi dated 7-3-2014, funds are approved by GOI for procurement of salt testing kits to 8 endemic districts. 12 STK per ASHA per annum has been approved at Rs. 15 per kit.

As per Order No. P.13015/06/2012-MCH dated 3-9-2012, ASHA incentive at Rs. 25/- per ASHA per month to test at least 50 salt samples per month for 8 endemic districts at household level has been approved.

Consumables of laboratory such as chemicals / re-agents and equipments, other office expenses are essential.

Therefore, an amount of Rs. 90.16 lakh has been proposed under NIDDCP for the year 2014-15.

Achievements:

Topline indicators	2011-12	2012-13	2013-14
Prevalence of IDD	440	174	153
Consumption of adequately iodated salt (15ppm) at the household level	57.77%	52.30%	58.76%

Justification:

Iodine is an essential micronutrient, which is required for regulating Thyroid Hormone in human body. Iodine is very essential for normal growth, development and functioning of both brain and body. Hence it is highly essential to create awareness in the community and early identification and treatment of IDD.

Deliverables:

Survey and resurvey of the endemic districts, supply of salt testing kits to all the ANMs & ASHAs. IEC / BCC activities is planned at the community level along with the ASHA training.

Funding proposed:

Sl. No.	Activity	No. Of units	Unit cost	Total	FMR code	Remarks
1	HR	1	0.416	4.99	D.1.A	
	Technical Officer	1	0.375	4.50	D.1.B	
	Statistical Officer / Staffs	1	0.208	2.50	D.1.C	
	LDC Typist	1	0.2708	3.25	D.2.A	
	Lab technician	1	0.22916	2.75	D.2.B	
2	Health Education and Publicity			12.00	D.3	
3	IDD Surveys/Re-surveys	23	1.00	23.00	D.4	
4	MBI kits for salt testing	90400	0.00015	13.56	D.5	
5	ASHA Incentive	7537	0.003	22.61	D.6	
6	Other activities (if any, pls. specify)	1		1.00	D.7	Office expenses & Lab consumables
Total				90.16		

2211:INFRASTRUCTURE MAINTENANCE **FAMILY WELFARE PROGRAMME**

BUDGET ALLOCATION FOR 2014-15

BUDGET GRANTS RELATED TO DEMAND NO. 22
FAMILY WELFARE PROGRAMME

Family Welfare/Reproductive & Child Health programmes are funded by Government of India for their major components and state is also sharing some part of the expenditure towards certain schemes. These Schemes are being implemented through State and Z.P. Sectors. Brief description and Budget Proposed for the schemes under State sector for the year 2014-15 for the implementation of Family Welfare Programmes is given in the following lines.

1	100% Centrally Sponsored Schemes	5489.39
2	State Plan Schemes	3515.48
	Total Allocation	9004.87

I 100% Centrally Sponsored Schemes

1. DIRECTION & ADMINISTRATION-STATE F.W.BUREAUs. 1018.76 lakhs **2211-00-001-0-01**

This is towards salary of the Officers and Staff of State Family Welfare Bureau including D & E Cell, Offset Press and CSSM / UIP & TA, GE, BE, Maintenance and TE and Procurement of Vehicles.

No of Units-4

No. of Staffs – 126

Salary Component - Rs. 160.20 Lakhs

Non-Salary- Rs. 858.56 Lakhs

2. CITY FAMILY WELFARE BUREAU: Rs. 50.00 lakhs **2211-00-001-0-03**

This is towards grant-in-aid for maintenance of City Family Welfare Bureau functioning under Bangalore and Mysore City Corporations.

No of Units-2

Salary Component - Rs. 50.00 Lakhs

No of Staff-8

Non-Salary- Rs. 0.00 Lakhs

**3. REGIONAL HEALTH AND F.W. TRAINING CENTRES: Rs. 222.41 lakhs
2211-00-003-0-01**

This is towards salary of Officers and staff, working in Bangalore and Hubli Centers. and also towards TA, GE, BE, and TE

No of Units-2

No of Staff-54

Salary Component-Rs. 176.79 Lakhs and Non Salary-Rs. 45.62 Lakhs

**4. TRAINING OF AUXILLIARY NURSE MIDWIFE
AND LADY HEALTH VISITORS (ANMs/LHVs) :Rs. 1666.72 lakhs
2211-00-003-0-02**

This is towards salary of Officers and Staff, TA, BE, GE, TE and stipend for trainees at 19 ANM Training Centres. As per GOI Norms 30 candidates is to be accommodated in each Training Centre and duration of Training is 18 months, during training each candidate will be paid Stipend of Rs. 500 per month.

No of Units-19

No of Staff-295

Salary Component-Rs. 577.61 Lakhs and Non-Salary –Rs.1089.11 Lakhs

**5. TRAINING OF MULTIPURPOSE WORKERS (MPWs) : Rs. 192.87 Lakhs
2211-00-003-0-04**

This is towards salary of Officers and staff working in Bangalore, Hubli and Mysore Centers TA, GE, BE, and TE and Stipend to trainees

No of Units-3

No of Staff-39

Salary Component-Rs. 105.51 Lakhs and Non-Salary- Rs. 87.36 Lakhs

**6. URBAN F.W. CENTRES RUN BY STATE Govt:Rs.938.61 Lakhs
2211-00-102-0-01**

This is towards salary of Officers and Staff working in the Urban Family Welfare Centres run by the State Government (Type I,II & III) TA, GE, BE and TE.

No of Units-23

No of Staff-269

Salary Component-Rs. 119.94 Lakhs and Non-Salary-Rs. 818.67 Lakhs

**7. URBAN F.W. CENTERS RUN BY LOCAL BODIES AND VOL.
ORGANISATIONS
Rs. 1000.00 lakhs**

2211-00-102-0-02

The provision is towards Grant-in-Aid for Salary of Officers and Staff working in UFWC's run byvoluntary organizations and Local Bodies.

No of Units-50, No of Staff-306
Salary Component- 1000 lakhs

8. Cost of Contraceptives supplied by GOI (kind] :
Rs.400.00 lakhs
2211-00-200-0-04

This is Notional provision towards book adjustment for the kind materials supplied by Govt., of India. The materials includes supply of Nirodh, Condoms, Mala-D, and Copper-T, E-Pills etc.,

* As per communication received from Govt. of India vide letter No. P17029/59/2012-NRHM-IV dt-25/05/2012, Non Salary component will be borne by state Govt.

STATE PLAN SCHEMES UNDER FAMILY WELFARE "2211"

1. Women Health CareRs. 16.05 lakhs
2211-00-103-0-05

This provision is towards salary of officer.

No of Officer-1

Salary Component- Rs.14.05 lakhs

Non Salary – 2.00 lakhs

2.Honararium to Anganawadi Workers/ Asha workersRs. 2561.00 lakhs
2211-00-103-0-11

With a view to strengthen outreach services, part time services of Anganawadi Workers were utilized earlier in certain identified districts. They were paid Rs. 500/- per month as Honararium. Now in place of Anganawadi Workers, Asha Workers are engaged in the out reach services. Hence to provide incentive to Asha Workers this allocation is made.

3. HEALTH KITS TO NEW MOTHERSRs. 0.00Lakhs
2211-00-103-0-73

Towards Non-Salary Component i.e. "Madilu Programme"

Others- Rs.0.00

SCP- Rs.0.00 TSP- Rs.0.00

4. State Health Transport Organization.Rs. 396.68 lakhs
2211-00-104-2-01

This is towards salary of 12 Officers and 107 staff working in the State Health Transport Organization (including officials at workshop) and towards T.A, G.E & P.O.L.

No of Units -1

No of Staff-119

Salary Component – Rs.246.25 Lakhs.

POL ,TA and GE-Rs. 150.43 lakhs

5. IPP-3 ProjectRs. 117.91 lakhs
2211-00-108-0-02

This is towards salary of 7 Officers and 15 staff working in IPP-3 Project and towards T.A,G.E & P.O.L.

No of Staff-22

Salary Component - Rs. 79.53 lakhs

POL ,TA and GE-Rs. 38.38 lakhs

6. DTCs & SIHFW under IPP-IXRs. 712.06 lakhs
2211-00-108-0-07

This is towards salary of 57 Officers and 152 staff working in IPP-IX Project and towards T.A,G.E & P.O.L.

No of Staff-209

Salary Component - Rs. 653.19 lakhs

POL ,TA, GE & Stipend -Rs. 58.87 lakhs

Annex 7.2a

NAME OF THE STATE		KARNATAKA			
BUDGET SUMMARY : 2014-15					
S. No.	Budget Head	2013-14		Proposed 2014-15	
		Financial Progress (Rs. Lakhs)		Budget (Rs. Lakhs)	%ge of total NHM budget
		Budget 2013-14	Expenditure (as on February 2013)		
PART I	NRHM + RMNCH plus A* Flexipool	70044.77	38102.87	109222.42	63.34
	JSY	6620.00	4610.18	9832.00	5.70
	JSSK mothers	4555.00	2319.37	4400.00	2.55
	JSSK infants	196.00	118.25	675.00	0.39
	Maternal Death Review	46.25	3.16	20.00	0.01
	Safe Abortion Services (incl. Training and Procurement)	75.98	0.39	74.65	0.04
	Line listing and follow-up of severely anemic women	16.25	0.00	20.00	0.01
	HBNC (incl. Training, excl. line listing of LBW babies and SNCU discharges)	0.00	0.00	0.00	0.00
	HBNC kit	100.00	0.00	50.60	0.03
	Line listing & follow up of LBW babies and SNCU discharges	0.00	0.00	2.50	0.00
	IYCF (incl. Training)	48.63	18.12	121.58	0.07
	Facility Based Newborn Care (SNCU, NBSU, NBCC) and Management of children with SAM (NRC, CDNC, Community Based Programme) - incl. Human Resources, Training, and New Construction)	1356.55	303.91	3766.05	2.18
	Micronutrient supplementation	0.00	0.00	0.00	0.00
	Child Death Review	14.00	0.30	33.25	0.02
	Terminal limiting methods (incl. HR, Training, and Procurement)	2660.68	1415.11	2574.05	1.49
	PPIUCD (incl. Training and Procurement)	55.00	9.45	138.98	0.08
	Interval IUCD (incl. Training and Procurement)	189.18	27.27	179.08	
	Door step delivery of contraceptive by ASHA	0.00	0.00	0.00	0.00
	Family planning indemnity scheme	65.00	63.00	96.00	0.06
	Adolescent friendly health clinics/ AFHC (incl. HR, Training, IEC/ Printing, and Procurement)	260.00	187.42	1002.57	0.58
	Menstrual hygiene (incl. Training and Procurement)	0.00	0.00	0.00	0.00
	WIFS (incl. Training, IEC/Printing, and Procurement)	0.00	0.00	845.85	0.49
	RBSK (incl. Human Resources, Training, New Construction, IEC/ Printing, and Procurement)	4531.64	1052.82	9062.26	5.26
	Other Human Resources	3522.99	4357.53	11324.55	6.57
	Other Training	1578.68	541.30	2604.37	1.51
	Programme management	1931.46	521.09	3397.90	1.97
	ASHA drug kit	200.00	32.80	193.60	0.11

	ASHA incentive (including MH, CH, FP and AH)	2377.78	2266.72	5450.79	3.16
	Untied Funds	7441.90	5561.10	11985.60	6.95
	Hospital Strengthening (including MCH wings)	13852.92	9520.93	15458.03	8.96
	Other New Construction	375.00	262.37	777.36	
	Other IEC-BCC NRHM	433.82	243.82	1105.92	0.64
	National Ambulance Service	4784.87	140.63	1496.12	0.87
	National Mobile Medical Units (and Vans)	0.00	0.00	0.00	
	Other Procurement	2877.92	359.13	5671.49	3.29
	Others	9877.27	4166.70	16862.27	9.78
C	Immunisation	2322.89	1617.62	2899.01	1.68
D	National Iodine Deficiency Disorders Control Programme (NIDDCP)	30.00	26.41	90.16	0.05
	GRAND TOTAL NRHM and RMNCH+A	70044.77	38102.87	109222.42	63.34
PART II	NUHM Flexipool	4830.14	6.50	9208.78	5.34
	National Urban Health Mission	4830.14	6.50	9208.78	
	GRAND TOTAL URBAN HEALTH	4830.14	6.50	9208.78	5.34
PART III	Flexipool for disease control programs	5329.51	4774.39	9486.34	5.50
E	IDSP	457.84	322.30	587.85	0.34
F	NVBDCP	1018.50	2402.47	1449.82	0.84
G	NLEP	337.90	169.18	441.63	0.26
H	RNTCP	3515.27	1880.44	7007.04	4.06
	GRAND TOTAL COMMUNICABLE DISEASES	5329.51	4774.39	9486.34	5.50
PART IV	Flexipool for Non-Communicable diseases including injury and trauma	2313.33	1556.04	8471.22	4.91
I	National Programme for Control of Blindness (NPCB)	733.71	814.50	2366.30	1.37
J	National Mental Health programme (NMHP)	664.80	0.00	1423.80	0.83
K	National Programme for the Healthcare of the Elderly (NPHCE)	0.00	0.00	1508.12	0.87
L	National Programme for Prevention and control of deafness (NPPCD)	104.96	1.51	298.23	0.17
M	National Tobacco Control Programme (NTCP)	0.00	0.00	431.43	0.25
N	National Oral health programme (NOHP)	0.00	0.00	16.20	0.01
O	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)	809.86	740.03	2427.14	1.41
	GRAND TOTAL NON COMMUNICABLE DISEASES	2313.33	1556.04	8471.22	4.91
PART V	Infrastructure maintenance	22469.16	24900.88	36059.41	20.91
	Infrastructure maintenance	22469.16	24900.88	36059.41	20.91
	GRAND TOTAL INFRASTRUCTURE MAINTENANCE	22469.16	24900.88	36059.41	20.91
	GRAND TOTAL NHM	104986.91	69340.68	172448.17	100.00

SELF-ASSESSMENT OF STATE PIP AGAINST APPRAISAL CRITERIA

Sr.No.	CRITERIA	REMARKS
1.	Has the state PIP been reviewed in detail by a single person to ensure internal consistency? If yes, by whom?	Yes, By Project Director (RCH)
2.	Has a chartered accountant/Finance manager reviewed the budget in detail?Has the State ensured that there is no double budgeting under any head? Has the State ensured adherence to all the costing norms laid down under NHM? Have the 'new activities' and 'activities to be continued' clearly marked?	Yes
3.	Has the district wise resource envelop conveyed to the districts? Has the State ensured that high priority districts get at least 30% more (i.e. HPD to be given a weightage of 1.3 Vs 1.0 against non high focus)?	Yes
4.	Has the state ensured that each of the components given in 5x5 matrix for RMNCH+A has been addressed in PIP?	Yes
5.	Is the budget consistent with stated components/objectives, strategies and activities? Would the proposed phasing of activities lead to targeted increase in delivery/utilisation of services?	Yes
6.	Has the PIP spelt out the strategy and activities for assuring quality of service delivery at public facilities? Has the State taken steps to ensure establishment and functioning of quality assurance committees in the districts?	Yes
7.	Are the supportive supervision structures at state and district / sub-district levels consistent with expertise required for programme strategies?	Yes
8.	Has the State reported progress on the conditionalities and incentives given in 2013-14?	Yes
9.	Has the State ensured that the statistics used in PIP (e.g. number of facilities DH/FRU etc., HR in each category, population etc.) have their source mentioned and are consistent throughout the document, across the sections?	Yes
10.	Has the State ensured that the HR sheet and infrastructure sheet given in annexure filled accurately?	Yes
11.	Has the State taken steps to plan and ensure monitoring of districts on the basis of activities and budget proposed in the PIP?	Yes