Proceedings of the Government of Karnataka

Sub: The Karnataka State Integrated Health Policy-reg.

Read: Proceedings of the State Cabinet, Govt., of Karnataka, Dt.30.01.2004

Preamble:

The Task Force on Health & Family Welfare had submitted its final report during April 2001.One of the important recommendations was to adopt the Integrated Health Policy, a draft of which was prepared by the Task Force and included in the final report. The Task Force also suggested that wide circulation and debate among all the stakeholders can improve the policy and its implementation, for better health for all. As per the said suggestion, workshops and meetings were held to discuss the draft Karnataka State Integrated Health Policy. The remarks/comments/revised formulations received from various departments and from the sub-committee of the High Level Co-ordination Committee were incorporated and the draft finalized. The finalized draft Karnataka State Integrated Health Policy was placed before the High Level Co-ordination Committee Meting held on 11.04.2003.The Committee approved the same. This policy has the following as its main components:

1. Vision for Better Health and Health Care.
2. Mission Statement on Health and Health Care.
3. Karnataka Health Policy Perspectives and Goals.
4. Karnataka Health Policy Components.
5. Policy Components On Primary Health Problems and Issues.

The Finance Department have given concurrence to this Health policy vide its Note No.FD 2107 Exp-5/2003,dt. 29.11.2003.The State Cabinet, Karnataka has approved the Karnataka State Integrated Health Policy in the Meeting held on 30.01.2004. Hence the following order.

Order No. HFW (PR) 144 WBA 2002,Bangalore Dated 10-2-2004

Under the circumstances explained in the preamble, Government are pleased to adopt the Karnataka State Integrated Health Policy as per the appended document with immediate effect.

By Order and in the name of the
Governor Of Karnataka

(SUSHAMA GODBOLE)
Under Secretary to Govt., (KHSDP),
H & FW Dept, Bangalore
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The Karnataka State Integrated Health Policy

Rationale for State Health Policy

The State has so far followed policy guidelines through the framework of successive five Year Plans developed by the Planning Commission, decisions of the Central Council of Health and Family welfare, Central health legislation and national health programmes developed by Central Government. Over a period of time, separate policies at the National level have been developed for Health (1983), which was revised in 2002, Education For Health Sciences (1989), Nutrition (1993), Drug Policy (1986 and 1994), Pharmaceutical Policy 2002,Medical Council of India (MCI) guidelines (1998,1999 and 2000), Blood Banking have served the state well in developing its health system, and will continue to be used as guidelines fro further growth.

A National Health Policy-2002 has been announced and provides a framework within which the Health Policy of the State Would refashion the elements therein to meet the current needs of the State. The State Health Policy would be based on the specific needs of the State and recognize regional disparities.

Health however is constitutionally a State subject. Health needs, defined socio-epidemiologically, vary between States and even districts, requiring more specific planning. Health expenditure is met largely by the State budget, with 82% of public sector expenditure on health from State Government of Karnataka and 18% from Central Government. A comprehensive Karnataka State Policy for the Integrated Health Development and functioning of the health sector is therefore being articulated explicitly, for the first time. The Policy, with a string emphasis on process and implementation, will be an instrument fro optimal, people oriented development of health services.

The State Health Policy would be based on the following premises-

- It will build on the existing institutional capacities of the public, voluntary and private health sectors.
- It will pay particular attention to filling up gaps and will move towards greater equity in health and health care, within a reasonable time frame.
- It will use a public health approach, focusing on determinants of health such as food and nutrition, safe-water, sanitation, housing and education.
- It will expand beyond a focus on curative care and further strengthen the primary health care strategy

- It will encourage the development of Indian and other systems of medicines.
- It views health as a reasonable expectation of every citizen and will work within a framework of social justice.

  More importantly it is intended to be guiding document that needs to evolve and be changed in response to changing Situations.

1. Introduction

1.1 Health Gains

During the past century and particularly after independence in 1947, several gains have been made in health and health care in Karnataka. Life expectancy at birth has increased from 37.15 to 61.7years and from 36.15 to 65.4 years for males and females respectively, between 1951 and 2001.The Infant Mortality Rate (IMR) declined from as high as 148/1000 live births in 1951 to 69 in 1981,and further to 57 in 2000(SRS 2000). In this sensitive key indicator, the goal of 60 fixed in the 1983 National Health Policy has been reached. The crude Birth Rate has fallen from 40.8/1000 populations in 1951 to 22.0 in 2000 and the total fertility rate from 6.0 children in 1951 to 2.13 in 1998-99.SmallPox has been eradicated. The State has become free of plague and more recently of guinea worm infection. The incidence of polio cases has been reduced to zero by December 2000 and until now, for more than two years, the nil status has been maintained. The progress in brining down Crude Death Rate by more than two thirds from 25.1 in 1951 to 7.8 in 2000 is noteworthy. Public Health care programmes richly deserve much of the credit for this. A brief picture of the gains is depicted below.

HEALTH INDICATOR	**1951**	**1971**	**1981**	**1991**	**2001**
Life expectancy at birth (years)					
Males	37.15	50.9	55.4	58.1	61.7
Females	36.15	50.2	55.7	58.6	65.4
Crude Birth Rate (per 1000 population)	40.8	37.1	28.3	26.9	22.0*
Crude Death Rate (per 1000 population)	25.1	17.0	9.1	9.0	7.8*
IMR (per 1000 lbs)	148	120	110	80	57*

Malaria (API)	NA	1.35	4.79	1.16	3.93
Leprosy (cases/1000 population)	NA	NA	31	16	2.45

*-Sample Registration System 2000

Further Improvements in the health Infrastructure over the years in Karnataka are apparent from the following table:

HEALTH INFRASTRUCTURE	**1970-71**	**1980-81**	**1990-91**	**2000-01**
No. Of Sub Centers	NA	3334	7793	8143
No. Of Primary Health Centers	265	300	1198	1676
No. Primary Health Units	917	1215	626	583
Hospitals	114	137	176	176
Beds	NA	24597	31432	43112
Doctors	NA	NA	4370	5202
Staff Nurse	NA	NA	4607	5317

NA: - Not Available

The Health and demographic scenario in Karnataka, compares favorably with the national average as could be evidenced from the following table.

DEMOGRAPHIC INDICATORS

SI.NO	Indicator	1951		1971		1991		1997		2000	
		K	I	K	I	K	I	K	I	K	I
1	Crude Birth Rate	40.8	39.9	37.1	41.2	26.9	32.5	22.7	27.2	22.0	25.8
2	Crude Death Rate	25.1	27.4	17.0	19.0	9.0	11.4	7.6	8.9	7.8	8.5
3	Natural Growth Rate	15.7	12.5	20.1	22.2	17.9	21.1	15.1	18.3	14.2	17.3
4	Infant Mortality Rate	148	NA	120	129	77	80	53	71	57	68

NOTE- K-Karnataka I-India NA-Not Available

1.2 Health Gaps

However, gaps remain. Large rural-urban differences remain, exemplified by IMR estimates of 70 for rural areas and 25 for urban areas (SRS, 1998). Despite overall improvements in health indicators, inter-district and regional disparities continue. The five districts of Gulbarga Division (Bidar, Koppal, Gulbarga, Raichur, Bellary), with Bijapur and Bagalkot districts of Belgaum division continue to lag behind. Under –nutrition in under-five children and anemia in women continue to remain unacceptably high. Women's health, mental health and disability care are still relatively neglected. Certain preventable health problems remain more prevalent in geographical regions or among particular population groups. Structural reforms as suggested by the task force on Health have to be made and more effective management practices imbued with accountability have to be introduced to ensure swift and effective local responses to Health problems.

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

2. Karnataka Vision Statement for better health and health Care:

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

The understanding of health was articulated by the World Health Organization (WHO 1948) as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", creating the ability to lead a "socially and

economically productive life"(WHO 1978). This is the ideal towards which individuals and institutions in society should strive.

Karnataka reaffirms the relevance of the strategy of Primary Health Care and the importance of practicing the principles of public health in order to reach this goal,

2.2 The state and her people are proud of the several achievements made in terms of improved health and better access to health care. However, recongnizing that some goals have yet to be met current concerns and commitments include-

- It is concerned about the current inequalities and inequities in health status by region, urban/rural location, gender, social and economic groupings.
- It recognizes the need to ensure that good quality health care services are evenly distributed and are always accessible to the citizens.
- It is aware of the escalating prices of diagnostics, medical therapeutic technologies and pharmaceutical products that are occurring as a result of globalization and the need to mitigate their impact.
- It is also recognizes the health impact and consequences of broader policies that affect employment, income, purchasing capacity, food security, education and pollution.
- The state acknowledges that judicious investment in health brings major gains in terms of human well-being, development and economic productivity.
- It acknowledges the growing recognition, that access to comprehensive health care has a poverty alleviating effect.
- It also recognizes the urgent need to address poverty and inequality, and the social forces that underpin them, as poverty and ill-health linkages are strong.
- It is committed to pursuing social development policies and increasing inter-sectoral coordination to accelerate improvement of health of all sectors of society in an equitable manner.
- It recognizes the critical role of the state to initiate and steer policies:
  - To ensure equity and quality of health care;
  - To promote the sustainable development of public health services;
  - To promote community/peoples participation in the governance of health services;

- To facilitate private and voluntary health sector growth as augmenting health care while maintaining professional and ethical standards and keeping in mind distributive justice;
- To provide required resources to different levels of health care, to improve accountability and transparency in the health sector;

3. Mission Statement on Health and Health Care

The mission of the Department is to provide Quality Health Care with Equity.

The State will provide improved access to good quality health care and promote an enabling environment for development of the health sector. It will endeavor to provide quality health care with equity, which is responsive to the needs of the people, and is guided by principles of transparency, accountability and community participation.

4 Karnataka health policy perspective and goals

1. To provide integrated and comprehensive primary health care.
2. To establish a credible and sustainable referral system.
3. To establish equity in delivery of quality health care.
4. To encourage greater public private partnership in provision of quality health care in order to better serve the underserved areas.
5. To address emerging issues in public health.
6. To strengthen health infrastructure.
7. To develop health human resources.
8. To improve the access to safe and quality drugs at affordable prices.
9. To increase access to systems of alternative medicine.

Indicators and systems for monitoring and evaluation that would allow review and assessing of progress towards achieving specific objectives that derive from the goals would be formulated and put in place.

5. Karnataka Health Policy Components

5.1 Scope of policy-comprehensiveness and integration

To facilitate the balanced development of health systems and services responsive to health needs and aspirations of people, Karnataka State considers it necessary to have a comprehensive health policy statement in

which different elements are integrated together and viewed as a whole. Various units and sub-sectors may evolve more detailed policy guidelines. However, this comprehensive statement will allow each one to be placed in the context of others. A Comprehensive approach is important, since at the point of delivery of services or the point of contact between the public, the patient and the provider, there is need for horizontal integration. The state will undertake measures to operationalise a comprehensive, integrated health service, with promotive, preventive, curative and rehabilitative health care services at primary, secondary and tertiary levels, linked together with good referral systems.

The Health Policy would be consistent with the separate policies that may be formulated for related social sectors and, along with the latter would constitute the character for social development of the people of the state.

5.2 Public health approach and primary health care strategies

The state recognizes the value of practicing public health and primary health care, for the common good of all citizens. It has committed itself to revitalizing these aspects. While the clinical or curative approach to health is focused on individual persons and their disease problems, public health tries to protect, promote, restore and improve the health of all people, through collective action. Programmes, services and institutions give priority attention to disease prevention and health promotion, responding to the health needs of the population as a whole, particularly the deprived. Public health addresses the basic determinants of health. Public health interventions address communicable disease transmission and attempt to reduce risk factors for other diseases. An evidence based approach using action research and other methods would be adopted to develop and fine tune strategies. This will be supplemented by feedback from the public, from patients and from frontline implementers or health personnel. This will enable the development of a problem solving approach that is area specific.

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

- Inter-sectoral coordination at all levels, especially at the districts and below;
- Community participation through Panchayat Raj Institution and other mechanisms and for a for involvement in decision making concerning their own health care;
- Equitable distribution of good quality care; and
- Use of appropriate technology for health.

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

Public health recognizes and attempts to address the socio-cultural, socio-economic and demographic factors that affect health status and implementation of health programmes.

The Karnataka State Health Policy would attempt to ensure adequate availability of personnel with specialization in public health to discharge the public health responsibilities in the state.

Towards this endeavor the state would take up measures:

To take up two months foundation course for newly recruited doctors in Primary Health Care, Administrative, Financial matters.

Upgrade course in Public Health for doctors and Public Health Nursing courses fro Staff Nurses.

Start Diploma and certificate Course in Health Management and Hospital Management through Indira Gandhi National Open University.

To include Health/sickness topics in primary, middle and higher level general education to the extent possible.

To enhance quality care," Quality Indicators" for primary, secondary and tertiary Health care will be standardized and continuously and tertiary Health care will be standardized and continuously monitored at various levels of Health and Medical care Institutions.

5.3 Equity in Health and Health Care

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

a) Region

The State is deeply concerned by recent data analyses that reveal unabating regional disparities in health status, in distribution of Primary Health Care facilities and their utilization.

The regional disparities are apparent in the composite health infrastructure index, based on: the (a) doctor: population and (b) Government hospital beds: population ratios and (c) drinking water facility of 40 or more Liters Per Capita Per Day (LPCD) as shown in the table overleaf. Out of the 56 relatively developed talukas in the state, only 15(27%) are in the Northern Karnataka region and the remaining 41 (73%)in the southeren. Among the 39 most backward taluks, as high as 33(85%) belong to the Northern Karnataka.

COMPOSSITE HEALTH INFRASTRUCTURE INDEX

Si NO	Division/Region	Relatively Developed Taluks			Backward Taluks			More Backward Taluks			Most Backward Taluks			Total Taluks	
		N0	*	% Share in total	No	*	% Share in total	No	*	% Share in total	No	*	% Share in total	No	Percentage
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1	Bangalore	13	25.49	23.21	17	33.33	42.50	16	31.37	40.00	05	9.81	12.82	51	100.00
2	Mysore	28	63.64	50.00	07	15.91	17.50	08	18.18	20.00	01	2.27	2.56	44	100.00
3	SKR	41	43.16	73.21	24	25.26	60.00	24	25.26	60.00	06	6.32	15.38	95	100.00
4	Belgaum	13	26.53	23.21	13	26.53	32.50	09	18.37	22.50	14	28.57	35.90	49	100.00
5	Gulbarga	02	6.45	3.58	03	9.68	07.50	07	22.58	17.50	19	61.29	48.72	31	100.00
6	NKR	15	18.75	26.79	16	20.00	40.00	16	20.00	40.00	33	41025	84.62	80	100.00
6	Karnataka	56	32.00	100	40	22.86	100.00	40	22.86	100	39	22.28	100	175	100.00

Note: * Percentage shares in the total taluks of the Division/Region

SKR-South Karnataka Region, Bangalore (U & R), Tumakur, Kolar, Chitradurga, Shimoga, Mysore, Chamarajnagar, Mandya, Kadagu, Dakshina Kannada, Udipi, Davanagere, Chikmagalur, Hassan.

NKR-North Karnataka Region, Belgaum, Bijapur, Bagalkot, Dharwad, Haveri, Gadag, Uttar Kannada, Gulbarga, Bidar, Raichur, Koppal, Bellary,

Information on the disparities in health status by social and economic background characteristics like religion, caste and standard of living can be indirectly inferred from the important indicator of child mortality and could be used as a yardstick for all practical purposes.

The following statement throws considerable light on the differences in the levels of infant and child mortality by these significant background characteristics, in Karnataka.

Background Characteristics	Infant Mortality	Child Mortality	Under-Five Mortality
Residence	44.1	12.1	55.7
Urban			
Rural	70.3	27.1	95.5
Illiterate	76.2	29.2	103.1
Literate < middle school complete	41.9	17.6	58.8
Middle School Complete	51.7	4.3	55.8
High School and Above	37.8	5.6	43.1
Religion	65.5	24.0	88.0
Hindu			
Muslim	49.5	17.0	65.6
Caste/Tribe	69.9	37.4	104.6
Scheduled Caste			
Scheduled Tribe	85.0	38.9	120.6
Other Backward Class	60.6	18.7	178.2
Other	56.4	14.2	69.8

Standard Living Index	82.2	38.5	117.5
Low			
Medium	54.6	13.6	67.5
High	38.2	12.4	50.1
Total	62.3	22.4	83.3

Source: - National Family Health Survey-II (1998-99)

Further proof of imbalances/differences in the health indicators is available from the district wise indicators reflected in the following statement.

DISTRICT WISE SELECTED KEY INDICATORS OF KARNATAKA

Si.No	District	Female Literacy %	Girls Married below 18yrs %	Current users of FP Method %	Birth order & above %	Safe Delivery	Complete Immunization %	Composit Index%
I		**GOOD PERFORMING DISTRICTS***						
1	HASSAN	59.32	15.20	75.10	19.70	69.70	92.80	81.55
2	SHIMOGA	67.24	16.50	69.30	22.80	83.00	92.90	80.37
3	KODAGU	72.53	22.00	70.60	18.80	79.40	94.80	80.06
4	D.KANNADA	77.39	4.50	63.70	32.00	91.50	86.00	78.77
5	U.KANNADA	68.48	15.00	66.00	27.20	86.10	89.90	76.11
6	UDUPI	74.02	4.50	63.70	32.00	91.50	86.00	75.97
II	**AVERAGE PERFORMING DISTRICTS***							
7	MANDYA	51.62	37.00	71.70	26.10	61.90	88.00	75.86
8	MYSORE	55.81	47.90	65.40	23.90	69.70	92.70	75.70
9	BANGALORE(R)	78.98	21.05	63.00	16.40	79.10	83.70	75.34
10	BANGALORE(U)	78.98	37.00	60.10	26.10	90.60	77.00	75.19
11	CHITRADURGA	54.62	30.05	59.90	34.40	53.80	88.40	73.98
12	TUMKUR	57.18	27.10	61.30	27.30	63.50	88.00	73.97
13	DHARWAD	62.20	36.50	61.20	37.40	65.30	74.80	73.03

14	CHAMARAJ NAGAR	43.02	47.90	65.40	23.90	69.70	92.70	72.18
15	CHIKKAMAGALUR	64.47	37.00	71.40	26.10	78.00	83.50	72.13
16	KOLAR	52.81	33.50	57.10	29.70	59.20	90.60	71.92
17	GADAG	52.58	36.50	61.20	37.40	65.30	74.80	69.72
18	BELGAUM	52.53	55.80	61.80	36.70	68.60	64.80	68.75
19	HAVERI	57.60	36.50	61.20	37.40	65.30	74.80	65.66
III	**POOR PERFORMING DISTRICTS***							
20	BELLARY	46.16	44.20	50.40	48.60	54.00	52.60	65.54
21	DAVANAGERE	58.45	35.50	59.90	34.40	53.80	88.40	65.43
	POOR PERFORMING DISTRICTS							
22	BIJAPUR	46.19	64.18	47.10	43.00	50.10	53.20	62.86
23	BIDAR	50.01	67.60	50.60	52.90	52.50	50.30	60.55
24	RAICHUR	36.84	57.10	45.40	52.80	48.00	37.20	58.34
25	GULBARGA	38.40	47.70	39.20	53.70	47.70	25.30	58.31
26	BAGALKOT	44.10	64.80	47.10	43.00	50.10	53.20	54.71
27	KOPPAL	40.76	57.10	45.40	52.80	48.00	37.20	53.09

Source: National Commission on Population, GOI, 2001

Note: - * The classification is based on the composite index

The regional and inter-district disparities would be factored into the mechanisms of allocation of resources among the regions and districts.

b) Disadvantaged groups

The Scheduled Castes and Scheduled Tribes will receive priority attention. Besides primary care, access to complete treatment, follow up and referrals, to secondary and tertiary care services at subsidized costs, will be assured. For indigenous people, a package commensurate to their needs will be developed and implemented.

c) Gender

The poor status of women's health, the declining gender ratio and poor coverage and quality of mother and child health services are areas of concern. Measures to improve women's health status and access to care will be implemented and closely monitored. Efforts will be made to increase the number of women doctors, senior and junior health assistants, male / female (Lady Health Visitors and Auxiliary Nursing & Midwifery) by providing adequate reservation for women in the health educational institutions and appointments and providing better residential facilities and personal security. Quality of maternal and child health services will be improved, particularly in emergency obstetric care. Widely prevalent conditions affecting women, such as anemia, low backache, cancer of the cervix, uterine prolapse and osteoporosis will be addressed. Services for psychosocial problems and emotional distress will be developed. Empowerment of women for management and monitoring of health services will be encouraged and supported. Programmes for the special needs of adolescent girls and boys will be developed in collaboration with the Department of Education. Enforcement of Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act will be strengthened and promotional measures taken to correct the declining gender ratio.

d) Vulnerable groups.

Innovative, flexible and collaborative approaches would be adopted for meeting the health needs of street children,. Out of school and working children, persons with disability and other vulnerable groups in the community.

e) Elderly:

With the increasing life expectancy, the proportion of senior citizens, that is, those of age 60 years and above would continue to increase. Necessary allocation of resources would be necessary for geriatric medicine and geriatric health care to improve the health status of the elderly and to make them socio-economically productive and happy. The State will promote research on geriatric issues and facilitate the establishment of appropriate geriatric health care facilities.

5.4 Quality of care

Having developed an extensive State wide health care infrastructure over the past five decades, an important policy thrust area in the next phase will be improvement in the quality of care and patient satisfaction. Quality care parameters and Standards of care would be developed for the different levels of Health Care Institutions. Mechanisms will be established to assure good quality medical and public health care in public institutions and to facilitate similar standards in the private and voluntary sector. Mechanisms will include accreditation, repeat registration, continuing education for health care personnel, patients charters and grievance redressal systems. Wherever necessary, appropriate legislation to facilitate these measures would be considered. Provision of good care would be the primary concern.

The possibility of the early enactment of the Karnataka Health Care Establishments Bill to ensure acceptable standards of care would be considered as an important step in assuring quality of care.

The Karnataka Health Systems Development Project has already taken initiatives for obtaining ISO 9002 / 1994 Certifications for six District Hospitals by February 2003 – in three services viz., Maternity Services, Blood Bank Services and Equipment Maintenance. The same will be extended to other services and in other District Hospitals in a phased manner. Standard Operating Procedures (SOPs) and Clinical Protocols and Guidelines will be laid down and adopted to ensure appropriate patient care and the rational use of drugs. The Citizens Charter, the Mission statement and the Quality Policy will be displayed in prominent place in the hospitals. Complaints / Suggestion boxes will be made available to patients for redressal of their grievances.

5.5 Multisectorality and inter-sectoral coordination

Inter-sectoral coordination has been inadequate even though its importance was recognized since the late 1970's. Working links, joint programmes and regular

communication will be institutionalized between the Directorate of Health and Family Welfare and the Departments of Women and Child Development, Education, Rural Development and Panchayati Raj, and the Public Distribution System in particular. Links with the Water Supply and Sewerage Boards. Pollution Control Boards will be developed with clarity regarding the roles of each department and areas of shared responsibility. Functional Mechanisms at village/ward level, taluk, district and state will be developed.

Intra-sectoral linkages will be strengthened between the Directorates of Health and Family Welfare, Medical Education, Indian Systems of Medicine and Homeopathy, the State Institute of Health and Family Welfare, the Drugs Directorate and the Rajiv Gandhi University of Health Sciences.

5.6 Public, private and voluntary sector partnerships

The state Policy recognizes the role of the voluntary and private sectors in public health care. Though already existing in an adhoc and often informal manner, public, private and voluntary partnerships will be further developed in a planned, systematic manner in order to develop in spirit and practice for better health care and also for optimal utilization of health resources. District and Taluk health action networks and issue-based networks will be encouraged with active participation from the public sector in such voluntary sector initiatives. Participation of voluntary and private sector will be enhanced through outsourcing certain services, in infrastructure maintenance and investments in health services.

5.6.1 Autonomous Medical Institutions

The important role of autonomous medical institutions is recognized. They encourage professional autonomy and the adoption of modern medical technology and provide specialized services of a high order. They would be encouraged to enhance their capacity to raise funds through appropriate user charges and other means so that they are able to enhance both the scale and quality of the services

they render. However, while doing so, the need to ensure that accesses to such services are available to the economically disadvantaged would be kept in mind.

5.7 Health Financing

Greater attention will be paid to equitable health financing systems in view of the rising costs of medical care and the large out of pocket payments that often have adverse consequences on the poor. Social and health insurances schemes, prepayment schemes, selection of cost effective strategies including use of generic drugs, central purchasing and better management of infrastructure assets, equipments and transport, would be the mechanisms that would be instituted for enhancing both coverage and quality of health care.

The government spending on health will be brought up to acceptable norms, as investments in the social sector are recognized to produce gains in human development. The optimum levels of budgetary allocations for health care would be reached in a phased manner. Equitable proportions of spending will be in the primary, secondary and tertiary levels (55%, 35% and 10% suggested by National Health Plan – 2002, Government of India) and between rural and urban areas. The Government would seek to implement, to the extent possible, the recommendation contained in the National Health Policy, 2002, to increase the State health allocation to 7% to the total Budget by 2005 and 8% by 2010. Resource flows will help increase access to quality health care in rural areas. Allocation and spending on health promotion will be enhanced in keeping with recommendations of the Central Council of Health and Family Welfare.

A system for state health accounts, with necessary databases, will be developed to monitor health revenue and expenditure, including those from externally assisted projects and centrally sponsored schemes. Capacities for financial and administrative management will be strengthened.

Budgeting and administration of health services will be made more flexible for timely appropriate decision-making and effective utilization of allocated resources without

compromising transparency and accountability. Pilot studies will be undertaken and encouraged to experiment with innovative health financing schemes such as community financing and social insurance, with particular focus on the rural and urban poor. Health insurance will be promoted. User charges for those segments of the society who can pay for the services will be levied. 'Rogi Kalyan Samithis' will be formed at those hospitals, which collect user charges for ensuring their effective utilization and for mobilization of additional resources resources locally by promoting public donation and contribution.

Private funding for the execution of health infrastructure creation and maintenance projects will be tried and, if successful, would be replicated.

5.8 Health Planning

Health Planning will be undertaken in consonance with the National Health Policy and Programme guidelines. The State will institutionalize such planning through the establishment of the planning and Monitoring Division in the Commissionerate of the Health and Family Welfare Services. Since there is an acute shortage of Epidemiologists in the State, the Epidemiological units will initially work at the State Level. Doctors will be encouraged to pursue Postgraduate Epidemiological Courses & depending on the availability of personnel such epidemiological units will be extended to all the districts as well. This will facilitate the planning and Monitoring Division in getting qualitative data on Disease Surveillance through the Health Management Information System.

Necessary expertise would be established in the Directorate of Health, including a Health Economist, a Sociologist and consultant in information technology. The Population Center, which is currently active in health and population, related research would also enhance the in-house professional capacity of the Directorate. The State Institute for Health and Family Welfare and the Rajiv Gandhi University of Health Sciences would also be involved in the planning of health care services.

5.9 Health Management and Administration

Skills in health management and administration will be strengthened through a process of recruitment of trained personnel and in-service training. Two cadres in the health services are envisaged, for medical care and for public health respectively. The formation of these two distinct cadres would, it is expected, enhance the quality and outreach of both the public health and clinical services.

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

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

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

- The Outsourcing of certain activities including contracting out non-clinical services such as cleaning, laundry, security, dietary department etc., will be continued and extended.
- The mismatch of specialists in secondary care hospitals will be minimized
- Vacancies of technical staff will be filled up
- Health management and hospital administration training courses on a regular basis to all the Health Programme Managers and Hospital Administrators will be taken up.
- The services of non-medical Management Specialists will be utilized to strengthen the District Health System and also National Health Programmes.

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

5.10 Environmental Health

Environmental health is an issue of great concern to the State. Unplanned industrialization, inadequate monitoring and control, and excessive use of chemical, pesticides, can and do have serious health effects on people. Motor vehicle fumes also add to the toxic chemicals in the air. The State will continue to undertake measures to control expose to these health hazards.

The State will encourage establishment of common facilities for the treatment of Biomedical waste not only in large cities but also in towns catering to a population of more than five lakhs, through Public-Private partnerships, with the assistance of the Pollution Control Board.

The state will ensure water quality of the accepted norms and standards through a monitoring and surveillance system.

Health education and Health promotion activities will be undertaken to promote personal hygienic as a safeguard against environmental health hazards.

5.11 Nutrition

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

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

The goals to be achieved by 2007 are:

(a) Reduction of under nutrition (Gomez classification) among pre-school children as follows – severe under nutrition from 6.2% (1996) to 3%; moderate under nutrition from 45.4% (1996) to 30%.
(b) Reduction in anemia among women from 42% (1998) to 30%.
(c) Reduction in anemia among children from 66% (1998) to 50%.
(d) Reduction in newborn with low birth weight from 35% (1194) to 10%.
(e) Elimination of blindness due to Vitamin A deficiency and elimination of iodine deficiency in goiter prevalent districts.
(f) Promotion of balanced, low cost diets using locally available foods for different age groups including children adolescents, pregnant and lactating mothers and the elderly.
(g) Improving household food security through poverty alleviation programme.

Short-term interventions would be formulated to set district wise goals and targets for appropriate nutrition interventions for vulnerable groups, particularly.

a) Focusing on under-twos with supplementary foods. Also, expanding the nutrition intervention net {Integrated Child Development Scheme (ICDS), Universal Immunization Programme (UIP), Oral Rehydration Therapy (ORT) } with wider coverage, regularity and better quality, with special attention to girls and underprivileged social groups.
b) Empowering mothers and families with nutrition and health education, with emphasis on caring for children and on low cost, locally available nutritious foods.
c) Control of iron deficiency anemia, Vitamin A deficiency and Iodine deficiency.

The indirect, long-term institutional and structural changes, as also recommended by the National Nutrition Policy, 1993 would be sought to be implemented. These include:

(a) Improved food security.
(b) Increased production of nutritionally rich foods such as pulses, oilseeds and ragi, and protective foods such as vegetables, fruits, milk, poultry, fish and meat;
(c) Improved purchasing power by active implementation of poverty alleviation programmers;
(d) Strengthening the public distribution system;
(e) Preventing food adulteration;
(f) Improving the status of women;
(g) Ensuring community participation

5.12 Population Stabilization:

Population stabilization through fertility decline has long been a goal of the state government, in consonance with national priorities. It is, however, realized that some of the causes for the state not achieving demographic goals as envisaged are inadequate social development, isolation of certain sub-groups of population, and lack of commitment on the part of service providers. It is widely recognized that the public sector, in particular has generated awareness, demand for services and has also provided widespread access to contraceptive and family welfare services, especially terminal methods, and Mother and Child health care. There have been resultant gains with declines in birth rates from 41.6 (1951-60) to 22.0 (2000), death rates from 22.2 (1950-51) to 7.8 (2000), and growth rates from 2.2 (1951) to 1.7 (2001 Census). The Total Fertility Rate (TFR) is 21.3 and the effective Couple Projection Rate (CPR) is 60.7% (2001). Thus the State is fairly near to reaching replacement levels of fertility. Data indicates decline with slower or stagnant declines). This momentum of decline is likely to continue. Improvement in social development, quality of life and gender development

will hasten the process of demographic transition. This will be an important component of the state strategy, with emphasis on districts in greater need.

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

- It will promote the spirit of voluntarism and will protect human rights. It will not adopt coercive strategies in any form.
- It will provide good quality contraceptive services, integrated with primary health care throughout the State. Reproductive technologies that are safe and effective will be used. Quality of care will be further improved with screening, follow-up services, managing and minimizing side effects. Demand for spacing methods will be enhanced. Male methods will be increasingly used, reducing the burden on women only. The government is committed to providing for informed choices and to seeking the voluntary involvement of the citizens.
- Responding to the specific situation in Karnataka, the State will develop a special package for districts with greatest unmet need in terms of Health and Family Welfare Services. It will endeavor to increase the, utilization of these services by making them user friendly, being particularly sensitive to the special needs of women.

The Objective of the State in terms of population stabilization are:

- To provide good quality family welfare services integrated with general health care services to all sections of the population, particularly in areas of greater need.
- To bring down the Total Fertility Rate to replacement levels in the State and in all the districts by 2010.
- To achieve a stable population by 2030.

Strategies:

1. The need of Reproductive Child Health (RCH) services will be estimated through a well-organized and meaningful Community Needs Assessment Approach at the grass root level.

2. Setting up a State Commission for Population and Social Development.
3. Making all efforts to ensure adequate facilities for good quality mother and child health care.
4. The State will attempt to develop a good civil registration system, working towards 100% registration of births, deaths. Registration of marriages will also be actively promoted and gradually made compulsory.
5. The State is concerned about increasing son preference that is adversely altering the gender ratio. It will implement legal measures such as. The Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act 1994 to prevent female foeticide. An awareness campaign would be mounted to educate the community regarding the intrinsic value of girl children.
6. Introducing life-skill and population education for adolescent girls and boys, using methods that capture their interest and responding to their needs.
7. Promoting delayed marriages for girls in particular and boys, delaying of the first pregnancy and spacing of the second child.
8. A network of committed NGOs and other allied systems of medicine will be involved in Needs Assessment and delivery of service.
9. Placing the responsibility of implementing the Population Policy on a number of Departments, in addition to Health and Family Welfare through an effective inter-sectoral coordination mechanism.
10. Efforts will be made to enhance the adoption of family planning measures among groups where fertility, due to various reasons, continues to be high.
11. All the districts, including those which are demographically advanced, will be given due attention for sustaining the levels they have achieved.

12.Educational, vocational and employment opportunities for girls will be considerably enhanced so that they become economically and socially empowered.

Plan Of Action:

- National Population Policy 2000 recognizes the link between high infant mortality and excessive population growth. A rapid reduction in neonatal deaths is called

for immediately. Suitable strategies would be formulated for this purpose, including intensive training in care of the newborn, and logistics and service interventions to rapidly bring down neo-natal deaths and consequently infant mortality.

- Spacing of births has been very poor in the State. One of the reasons is due to inadequate skill based training in I.U.D. insertion. Training strategy will be changed in the form of decentralizing the training to Community Health Center (CHC) / Primary Health Center (PHC) level so that hands-on training will be effective and trained personnel available in larger numbers.
- The inject able immunization services are not reaching certain remote pockets in the rural areas and more so in the urban slums. Mechanisms will be devised to hire out the immunization services to private clinical establishments on the basis of service charges and Anganawadi Workers will also be involved with suitable training.
- Focussed "District Plans" will be prepared for those districts which are showing slow / poor performance, implement and monitor the programmes towards achieving greater speed in population stabilization.
- Keeping in view the present demographic status and state's financial and other capabilities, realistic goals in respect of population, child health and maternal health at the end of 2010 will be worked out and necessary programmes will be taken up to achieve these goals.

5.12.1 (a) The policy will address the increasingly adverse sex ration. The Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act 1994 would be strictly enforced.

(b) The law relating to age at marriage would also be strictly enforced.

5.12.2 A special package for family welfare will be devised for the seven northern Districts. The unmet needs of the urban slums will be addressed with increased utilization of the health and family welfare services by making them user friendly and sensitive to the special needs of women.

5.13 Education for Health Personnel

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

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

A situation analysis reveals many ills in the education system of health personnel, in the institutions and in professional practice and conduct. These include a rapid expansion in quality, namely numbers of educational institutions and seats, at the expense of quality. In post-graduation, there is a mismatch between the specialties, with certain specialties remaining under represented. Growing commercialization in the establishment and management of educational institutions, decline in academic standards, dilution of professional standards and ethics are identified as the specific areas that need to be addressed with concern.

Keeping these and other factors in view, certain principles and strategies for education for health personnel are proposed to be evolved and adopted:

- The focus will be not only on medical education of doctors but on all allied health professionals and on Indian Systems of Medicine and Homeopathy. The functioning of a variety of health professionals in teams makes for better health care services to respond to people's needs. Conducting team training will be encouraged.

- Efforts will be made to improve the infrastructure and functioning of existing educational institutions of all systems at all levels to bring them up to acceptable norms laid down by the respective Professional Councils. A study of financial and other requirements of these institutional will be made for ensuring sustainability of these institutions.
- In order to ensure quality, norms regarding number of institutions and number of seats will be respected, subject to any special needs and circumstances. Issuing of Essentiality Certificates and University affiliation for new Medical, Dental, Nursing, Pharmacy and Physiotherapy colleges will be critically viewed with an exception for institutions in the under-served areas of Karnataka.
- Similar guidelines would apply for Ayurvedic, Homeopathic and Unani Colleges in the State.
- Each Medical College will be required to take up some PHCs for training and service.
- The Para-medical College will strive to maintain standard of education in various Para-Medical Diploma Courses.
- The standard of education in various Para-medical Diploma Courses will be maintained.
- Essential services will be maintained round the clock in the teaching hospitals.
- Closer working links will be encouraged between the University, educational institutions and health services for mutual advantage and development. Health Service professionals may be permitted to undertake some teaching responsibilities, while a part of the teaching of undergraduates and postgraduates could be based in district and taluk hospitals, as also in CHCs and PHCs. Teaching staff also will be exposed to field situations so that their teaching and research could be of practical relevance and importance.
- Improvements will be made in the pedagogy of health science institutions. The University and Para-Medical Board will organize Teacher Training Programmes on Teaching Methodology for health sciences. It will be mandatory for teachers to undertake these courses. Learner centered, Problem-solving approaches will be used. Each institution will be encouraged to initiate and run educational units with

the specific objective to improve teaching capacity. Systematic feedback from students will help to modify training programmes. Performance appraisal of teaching faculty will help to further develop their competence.

- State Councils such as Karnataka Medical Council, Dental Council, Nursing Council, Pharmacy Council etc. will be strengthened and rendered more effective. The Committee will develop good information and knowledge base to this end.

A Co-ordination Committee at the State level will bring together representatives from different councils, including Indian Systems of Medicine and Homeopathy (ISM & H) along with Government policy makers and University / Board representatives to address issues raised by the National Education Policy for Health Sciences. The Committee would be alert to trends in the sector including negative trends mentioned earlier and make suggestions for regulations and correctives.

5.14 Rational Drug Policy

The State is aware of the technological advances and the progress in terms of increased production, high turnover and exports made by the pharmaceutical industries in the country and State. The State will take steps to make available essential drugs of good quality in adequate quantities in all Government hospitals and will take further necessary steps to curb the menace of spurious / adulterated / not of standard quality drugs.

The State will ensure compliance with the provisions of the Drugs and Cosmetics Act and Rules, and allied Drug Legislations.

The State supports the concept of essentiality, based on criteria of therapeutic needs, efficacy and safety. Essential drug lists for different levels of institutions will be followed.

Dissemination of information on drugs concerning essentiality and essential drugs list to medical professionals, pharmacists and to the citizens will be promoted. Patients right to information about harmful, hazardous, irrational drugs will be ensured.

The State will continue to support the system of monitoring Adverse Drug Rations (ADR) already initiated by the Karnataka State Pharmacy Council.

The State will strengthen the Drug Control Enforcement machinery by providing adequate staff with required qualification.

Key Staff and Doctors will be educated in rational use of Drug, and in Drug Policy Issues.

Measures to increase efficiency, economy and transparency in drug procurement, warehousing and distribution will be implemented.

The State will support strategies in co-ordination with professional and consumer bodies to ensure safe drugs and rational use of drug for people.

A state drug formulary and therapeutic guidelines will be developed, adopted and regularly updated.

Steps will be taken to modernize Drugs Testing Laboratories for speedy and accurate test and analysis of drugs.

5.15 Blood Banks:

Availability of blood and blood components and functioning of blood banks will be improved. Preparation of blood components leading to better utilization of blood will be encouraged.

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

The Health Department will lay down specific standards for procurement of medical and diagnostic equipments, Health accessories and Health Education material.

Internal mechanisms would be established, with expert assistance, to enable the formulation of standards of equipment, the principles of maintenance and inspections and related issues.

5.17 Medical and Health Research

Research, and the spirit of enquiry upon which it is based, provides the critical questioning and thinking required in the quest for new solutions to old and new problems.

Rapid social, technological and environmental changes are posing new disease and health problems. There is a need to actively study these changes and evolve our own ways of addressing them.

Karnataka State prides itself of having premier scientific, technical and research institutions in various fields. The State will partner with these institutions and actively foster systematic data collection and research in the public health services and educational institutions so as to inform the planning process. It will develop the necessary bodies and facilities for this purpose. A research advisory group, within the Department, would steer the research process, raise funds and review technical quality and achievements.

5.18 Indian Systems of Medicine and Homeopathy (ISM & H)

The country and Karnataka have evolved and cherished a rich heritage of traditional Indian systems of medicine and healing. These classical systems of Ayurveda, Siddha and Yoga have the world's earliest written texts and pharmacopoeia. They have survived through the centuries and are currently gaining increasing global recognition and respect for their insights and holistic approach to healing and efficacy. They have a large number of practitioners, educational institutions, and pharmacies / centers where medicines are prepared. They are linked to local health traditions and practices. Other systems as Unani, Tibetan medicine and homeopathy also contribute to health care in the State.

However, ISM&H has not received sufficient attention in health planning and resource allocation. These systems will receive increased support to promote their optimal growth. They will be involved more in health decision-making and in provision of health services, so that people can freely exercise a choice.

5.19 Health Promotion

Health Education and information, Education and Communication (IEC) activities have in the past few decades been fragmented. They are linked to specific programmes each of which has an IEC component. It is envisioned that health promotion will receive

a major thrust and become the most important health intervention in future. It will move focus from communicating information to promoting positive behavior changer and from being instructive to becoming empowering. It will address health determinants, diseases prevention and control, using appropriate methods and idioms to different settings and varied groups such as school children, youth, women, workers/farmers etc. It will enable people to increase control over and participate actively in improving their health. Local folk media will be used.

The state will allocate adequate resources for health promotion and take measures to build capacity for health promotion, using talent available from all sectors and promoting creativity. School health programmes will be implemented actively including availability of drinking water and toilet facilities, especially for girls. Health promotion measures would at all times take advantage of technological advancements such as tele-medicine.

6. Policy Components on Priority Health Problems and Issues

6.1 Communicable / infectious diseases

The thrust would be given to health education aspects through field workers. This would be through inter-personal contact and group discussions, especially regarding personal hygiene and cleanliness in and around the dwelling places. Though apparently simple, this message would go long way in prevention of communicable diseases, especially water borne diseases.

Japanese Encephalitis:

Japanese Encephalitis being reported in some parts of the State during the post monsoon season. Regular surveillance and treatment activities are being carried out during the endemic season of the disease. Bellary district is the most affected in the State. The other districts where the disease occurs usually are Mandya, Kolar, Raichur and to some extent Bangalore Urban, Chitradurga, Davanagere and Koppal. Entomological studies would be taken up intensively by the District Surveillance Unit. Zilla Panchayats and NGOs would be involved in providing health education to the population at risk, for

prevention of man-mosquito contact, segregation of pigs during the epidemic season and rehabilitation of children affected by this disease.

The proposal for formation of a society for control of mosquito borne diseases is under the consideration of Government. Formation of society would ensure an integrated approach to vector control measures, with a common strategy.

a) **Tuberculosis:** In Revised National Tuberculosis Control Programme (RNTCP) the two objectives of achieving 85% cure rate among new smear positive pulmonary TB cases and case detection of more than 70% of new smear positive pulmonary cases after achieving cure rate of 85% have been incorporated with a view to rapidly reducing the incidence of TB in the community.

Targets are fixed based on the annual risk of infection. The annual risk of infection at present is 1.7, which means that 85 positive cases per lakh occur in the community every year. Of this about 60% or 51 cases per lakh approach a health facility for treatment. All these cases have to be identified, treated and cured. Hence the target of 50 per lakh positive cases or 59% of cases would be sought to be achieved.

The two objectives have not been fully achieved since it is not possible to control all the factors influencing the cure rate and case detection rate. However, it is assumed that as the programme gets established and with improved awareness among the community, it would be possible to achieve a higher case detection and cure rate over a period of 5-10 years. In order to increase the case detection rate to more than 70% it is necessary to involve all health institutions (government / private / NGO) and all systems of medicine. The Revised National Tuberculosis Control Programme (RNTCP) aims at this kind of expansion, which will take some, more time but all necessary efforts for early achievement of these targets would be continuously sustained.

Attempting to improve case detection before achieving 85% cure will lead to unacceptably high rate of mortality and drug resistance. It is also known that a good programme with high cure rate will attract chest

symptomatic for sputum examination, thereby increasing the case detection rate to more than 70%. In Karnataka, 4 districts have already crossed the target zone and are detecting more than 70%. When once the incidence of new cases is controlled, the pool of cases in the community would get gradually depleted. Due to natural dynamics of TB, 1/3 rd of the cases are removed every year due to death and spontaneous cure.

b. HIV / AIDS

The State will take proactive steps to create public awareness regarding this rapidly growing problem. Preventive education will be undertaken among adolescents, workers in the organized sector, and women through Sanghas and women's organizations. In particular, such preventive education would include young adults. The general mass media would be intensively inducted for this purpose.

Specific strategies would include the following:

- District based Voluntary Counseling and Testing Centers (VCTC) will be established in all district hospitals.
- Treatment to reduce mother child transmission will be introduced.
- Home-based care would be encouraged and supported.
- There will be no discrimination in providing treatment facilities in all public sector hospitals. Private sector institutions will also be advised to be non-discriminatory
- Training of staff will be undertaken.
- Treatment facilities for Reproductive Tract Infections (RTIs) and Sexually Transmitted Diseases (STDs) will be expanded, with conscious efforts to maintain privacy and confidentiality.
- Measures will be enforced to reduce transmission of HIV through blood transfusion and blood products.
- Strong advocacy and social mobilization efforts will be made at all levels.
- Surveillance and operational research will inform and guide the development of the programme.
- NGO and philanthropic organizations will be supported to run care centers for patients where home care is not possible.

- The State will promote collaboration between the public, private and voluntary sectors, all concerned departments and with citizens groups in responding to the problems of HIV / AIDS.
- The control of HIV / AIDS is closely linked to control of sexually transmitted diseases and Reproductive Tract infections. Hepatitis B and C. The overlapping elements in strategies will be made convergent and all will be operationalised through general health services.
- The State would be sensitive and responsive to problems such as children with HIV / AIDS, orphaned children, abandoned patients, legal issues etc.

c) **Vector borne diseases:**

Early diagnosis and prompt treatment through active and passive surveillance, qualitative laboratory diagnosis and reporting systems, vector control with special emphasis on bio-environmental methods, personal protection, prediction, early detection and effective response to outbreaks: health promotion and most importantly involvement of people through pro-active social mobilization efforts will be sustained. The Health Research Center (of Indian Council for Medical Research) Bangalore, field station will be actively involved in implementing vector control strategies for the State, for filariasis especially in endemic districts, in addition to the general principles of vector control and the guidelines of the national filarial control programme, treatment of acute filariasis, detection and treatment of microfilaria carriers will be undertaken. Single dose mass diethyl carbamazine citrate (DEC) therapy will be considered after expert review.

The increasing spread of dengue fever is recognized as a public health problem. The new expanded disease surveillance system, backed by the public health laboratory process will help to record emerging epidemiological patterns. Facilities for diagnosis and treatment will be made available; health promotion for households regarding domestic and peri-domestic measures to reduce vector breeding; adoption and implementation of urban, municipal byelaws to control vector breeding grounds will be initiated.

6.2 Women's Health

The State has several ongoing schemes for girl children and women. These will be expanded, strengthened and developed further.

The State recognizes several societal factors that influence and affect women's health, such as lower social status, social exclusion and isolation: lower access to and utilization of health and other services especially in some districts; poverty, leading to overwork, fatigue, stress, under nutrition, and a host of effects; environmental degradation reducing access to water and fuel; migration for economic reasons increasing risk of ill-health; violence in the family, at the workplace and in public places. Along with education, employment, mobility, empowerment and political participation which have positive influences. The state is committed to women friendly policies in all these areas. It will also undertake reviews of the implementation of schemes addressing these issues and studies of their impact with a view to improving the effectiveness of these measures.

More Specifically, in health, policies will work towards the following:

- There would be a sustained focus on the entire life course or life cycle of women. This means ensuring adequate nutrition and physical and social conditions for mothers during pregnancy, providing access to good mother and child health services, implementing measures to prevent female foeticide and female infanticide.
- Focus on the woman / women as whole including physical, psychosocial and emotional aspects.
- Using strategies empowering women for health, where women are important agents for change.
- Using a community health and community development approach that facilitates community mobilization, community participation, community organization and community action, wherein the role of men is also important. As many health problems of women have social roots, this strategy will allow for social interventions rather than medical interventions only.

- Health promotion for women focusing on empowerment and community action.
- Access to care for women will be enhanced by increasing the number of women health professionals, particularly at primary care levels and in the first referral units. Provision of adequate living facilities, equipment and drugs will also be ensured at these centers. Priority attention will be given to backward areas.
- Special attention will be given to developing counseling and mental health services for women, with trained professionals and by short term training of health workers at primary care levels to respond to the needs at community level.
- Facilities for diagnosis and treatment of Reproductive Tract Infections (RTIs) and Sexually Transmitted Diseases (STDs) will be made available at the primary care level supported by a referral system.
- Education regarding reproductive health will be given high priority.
- The health policies regarding women's health would give emphasis to the following:
    - Women empowerment by providing more education and job facilities.
    - Male participation: As our society is male dominated, the need for male participation in all spheres of women health would be stressed.
    - Grass root level workers, who are the back bone of these programmes, would be given further training, facilities and incentives.
    - Intensive monitoring to ensure accountability at all levels would be introduced.
    - Under Reproductive Child Health (RCH) – Intervention, by way of incentives, in 'C' category districts such as honorarium for doctors, nurses and cleaning personnel conducting deliveries between 8.00 PM to 7.00 AM has resulted in an increase of about 30% in institutional deliveries. Transport facilities for pregnant women

requiring referral to higher centers for safe delivery under RCH has also been perceived as beneficial. It is proposed to continue these benefits.

6.3 Children's Health

Karnataka State has a special interest in and commitment to the health and well being of children during their intrauterine period, infancy, toddler years, school age and adolescence. Its interventions reach out through Maternal and Child Health programmes, through Anganwadis of the Integrated Child Development Scheme through schools and colleges. A policy document, "The State Programme of Action for the Child" brought out in 1994, reiterated the state's commitments, in keeping with the spirit of the National Policy for Children in 1974, the World Summit for Children in 1990, the four sets of Rights of Children (to survival, protection, development and participation), and the National Plan of Action: A Commitment to the child, adopted in 1992. The State will be guided by the principle underlying the national plan, namely **"first call for children",** wherein the essential needs of children will be given highest priority in allocation of resources of all times. This will also be applied specifically to the spheres of health and nutrition.

Specific efforts will be made to reach children, especially from socially deprived groups, who are still not reached by the ICDS and who are out of school. A multi-sectoral approach will be used to provide services for working and street children, and to address underlying issues that result in their having to work.

- The State will undertake all efforts to ensure child survival with no damage to the processes of growth, maturation and development. Continuing efforts will be made to reduce infant and neonatal mortality.

  The coverage and quality of services of the Integrated Child Development Scheme (ICDS) with regard to health, nutrition and care will be improved by providing adequate resources and training of all levels of personnel. Supervisory and monitoring systems will be strengthened. Constructive partnerships with gram Panchayats and parents will be developed and linkages with Primary Health Center Staff will be made more functional and regular. Quality of food given to

children will be ensured and health promotion and nutrition education will be undertaken more proactively. The most needy children, including those belonging to scheduled castes and scheduled tribes, will receive particular attention.

6.4 Mental Health

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

However, there continue to be shortages of trained personnel in Karnataka, compounded by misdistribution of facilities and staff with grater urban concentration, especially in big cities.

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

- Improving training in psychiatry and psychology in undergraduate medical and general nursing courses.
- Introducing district mental health programmes in a phased manner by strengthening psychiatric teas and services at district hospital level and planning for counseling services at taluk hospital level.
- Ensuring minimum standards of care for mentally ill patients.
- Providing for mental health care at primary care level by training primary health center medical officers and staff, using manuals already prepared by National Institute of Mental Health & Neuro Sciences (NIMHANS).
- Encouraging and making provision for care facilities for persons with chronic mental illness, through NGOs and other organizations.

- Introducing the mental health component into school health services on a pilot basis in different districts and later expanding it.
- Supporting broader societal strategies that address violence, particularly against women; discrimination in any form; substance abuse; poverty and destination.
- Establishing institutional mechanisms at the State level through which mental health care services can be promoted.
- Caring for and nurturing health care personnel, who work under difficult conditions.

6.5 Prevention and control of non-communicable diseases

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

- It will use a public health approach by adopting strategies to reduce the risk factors for these diseases and by using health education to promote healthier life styles.
- It will initiate policies to discourage the use of tobacco, and alcohol, which is on an increasing curve due to intensive advertisement and aggressive marketing. Over 25 serious diseases are associated with the use of tobacco and several diseases and social problems are linked to alcohol. These are described as communicated diseases. They are both addictive substances. Policies that would reduce consumption of these include bans on sponsorship of sports and entertainment; bans on direct and indirect advertising; higher taxation; sales to be permitted to persons over 18 years; sales to be barred within certain distances from educational institution; and public education, especially among children and youth as part of life skills education; education of health personnel.

In the case of tobacco, measures include banning smoking in public places to prevent passive smoking and working towards alternative crops and alternative employment for those engaged in its cultivation and production. Chewed tobacco in particular is a growing problem with widespread use among women (40-60% in different groups) and even among tobacco control includes smoked and chewed tobacco. The appropriate measures would be taken to the extent feasible to mitigate the use of tobacco.

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

Education regarding the deleterious effects of tobacco and alcohol will be included in school and college curricula.

- Diagnosis and treatment for non-communicable diseases will be made available at primary health care level. This will require preparation of treatment guidelines and supply of diagnostic equipment and drugs.
- Recording and reporting of non-communicable diseases as per the international classification of diseases will be introduced into the diseases surveillance system.
- The cancer programme will also be strengthened by discouraging the use of tobacco, health education, early detection and provision of treatment. Facilities will be made available at regional level and later in a phased manner in some districts where medical colleges exist. Grants provided by the national programme will be fully utilized.

6.6 Disability

It is estimated that about 2% to 3% of the total population of Karnataka consist of persons with disabilities, with 76% in rural areas and 58% men. Disabilities include locomotors, visual and learning disabilities, hearing and speech impairment, mental illness, mental retardation, multiple disabilities, leprosy cured with disability etc.

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

The Department of Health and Family Welfare will increase its role and responsibility in respect to disability, by way o0f prevention, early detection and intervention and will, for this purpose, coordinate with the Directorate of Welfare of the Disabled, under the Department of Women and Child Development, which is currently the administrative Department concerned.

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

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

6.7 Occupational Health and Safety

Though services exist in some large public sector and private sector units, this specialty needs greater support. The focus will be on the workers in the agricultural and unorganized sectors who comprise the largest proportion of the work force and who are at risk because few safety devices and precautions are used. The services of

institution like the Regional Occupational Health Center and experts will be utilized to evolve a strategy.

6.8 Dental Health/Oral Health

The awareness about health care is poor especially in rural areas. The increased life expectancy of the population and widespread prevalence of oral diseases warrants a serious thought for immediate strengthening of the existing oral health delivery system in the State.

The establishment of a three tier Oral Health Care delivery system in Karnataka would be planned, namely:

a. Primary Oral Health Care
b. Secondary Oral Health Care
c. Tertiary Oral Health Care

Primary Oral Health Care comprises of mainly (a) Health Education for promotion of oral health and (b) various Preventive Procedures for Oral Health. Secondary Oral Health Care comprises of secondary level Oral Health Care given by qualified dental surgeons at community Health Centers and taluk level Hospitals. The Secondary Oral Health Care rendered at these hospitals includes both preventive and also curative treatments. The Tertiary Oral Health Care programme comprises of specialty treatment, which will be made available at each district level hospital.

Necessary restructuring of the implementation, monitoring and supervision mechanisms for these programmes within the department would be made.

Other strategies would include-

- Proper utilization of mass media for regular Oral Health Education
- Involvement of local non-governmental agencies in programme operation for better implementation of the programme.
- Programme for increasing awareness amongst schoolteachers regarding Oral Health.

Apart from the Government Dental College, Bangalore, other good Dental Colleges in each division would be identified so that such colleges, dental association and other social organization adopt some villages for comprehensive dental care delivery.

6.9 Emergency Health Services and Trauma Care

There is pressing need for strengthening and expanding Emergency Health Services and Trauma Care. This would include not only accidents and injuries but also Emergency Obstetric Care (EOC), snakebites.dogbites, insect stings and other medical emergencies. The timely availability of Anti-Snake Venom, antidote for Organo Phosphorus poisoning and anti Rabies vaccine will be ensured. Networking of Communication, links and transparent facilities will be established.

Training in first-aid and life support system will be imparted to school children, college students, teachers, factory workers, drivers, bus conductors, traffic police and paramedics.

Efforts will be made to enforce preventive measures such as wearing of helmets and seat belts.

The Citizens Right to accessing care for first line critical care in any hospital, as determined by the Supreme Court, will be widely publicized.

7. Cross Cutting Policy Issues

7.1 Medical and Public Health Ethics

Admittedly, there is considerable scope for improving the efficiency of the public health services and for enhancing the level of confidence in these services. Concerns regarding the current levels of adequacy, acceptability, quality, performance and accessibility of the public health services are reflected in the report of the Task Force on Health and Family Welfare. Necessary structural changes in the system and appropriate institutional and procedural changes for correcting these observed deficiencies would be instituted.

- The state will promote the principles and practice of medical ethics in all its institutions, in all health sectors and in all systems of medicine.
- The primary of public health will be restored and the principles and ethics of public health would form the core of the public health services, while maintaining the necessary attention to and level of clinical services.

7.2 Community Participation and the Role of the Panchayat Institution

Health and its related sectors such as sanitation and drainage, nutrition, safe drinking water practices and the like are doubtless the primary responsibility of the state. However, by their very nature, the successful implementation of programmes in these areas would be heavily dependent on the involvement of both the community and the individual families. It is essential, therefore, to ensure the cooperation and involvement of the community in the processes of planning, implementation and monitoring of health services. Such community participation would be through involving and assigning responsibilities to NGOs, voluntary social organization such as Mahila Mandals, Youth Clubs and the like. Mechanisms would be developed for the active involvement of these local community organizations.

In this context, it is recognized that the Panchayat Raj institutions have a major role in the provision and management of health services. They have a statutory responsibility in this matter and all assistance and encouragement would be given to Panchayati Raj institutions to discharge this responsibility to the satisfaction of the people they represent. Necessary mechanism for training the members of these institution, monitoring performance and providing both technical and management expertise would be developed. It is recognized that the State shares, with these institutions, this responsibility of providing adequate health services.

7.3 Institutional Structure For Implementation

Implementation of this health policy would imply that necessary structural changes are made within the health services themselves and, towards this end, the reorganization of the Directorate of Health Services has already been instituted. However, the Health policy does not stand-alone. It has to be consistent with and integrated into polices that deal with development sectors related to health. This, it is recognized would be effectively possible only through a high level mechanism that would oversee and coordinate these various sectors. It is therefore, envisaged that-

- At the State level, a Commission on Population and Social Development would be constituted for consideration of all policy and coordination issues relating to the social sectors of development, including health, with Chief Minister as Chairman, and would include the Ministers concerned with Health, Finance, Medical Education, Social Welfare, Women and Child Development, Education, Rural Development and Panchayati Raj and other rural development sectors as may be appropriate, and experts.
- At the apex administrative level, Committee on population and social development would be constituted with Chief Secretary/Development Commissioner as Chairperson and including the Principal Secretaries of the Department of Finance, Health, Education, Social Welfare, Women and Child Development, Rural Development, and other concerned departments. This Committee would be responsible for planning, monitoring and coordinating the activities of these related social sectors, including heath;
- The review mechanisms in the zilla panchayats and the other Panchayati Raj institutions would be strengthened towards ensuring effective, coordinated implementation of health services.
- Inputs from the health sector would be built into all development programmes to ensure maintenance of public health standards.

8. CONCLUSION

This policy document is just one step in the overall ongoing policy process that makes explicit the current concerns, intention and priorities concerning health.

The confidence evoked in the public by those who manage and deliver health services is critical in transforming policies and programmes into action for social good. It is recognized that there are conflicting interest in the provision of any social service, including health, which often result in pressure groups and inhibiting factors in implementation. However, it is reiterated that the only criterion that would imbue the health services would be larger public good. The

improvement and enhancement of health services would be guide by this sole principle.

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