**INDIA**

**INTEGRATED DISEASE SURVEILLANCE PROEJCT**

**PROJECT LAUNCH MISSION**

**AIDE MEMOIRE**

**November 8 – 10, 2004**

1. A World Bank mission[1] reviewed progress in the Integrated Disease Surveillance Project (IDSP) following the Launch Workshop in New Delhi on 8-9 November 04. In reviewing progress, the team met with JVR Prasada Rao (Secretary for Health, GOI), Jyothi Rao (Additional Secretary, Health), BP Sharma (Joint Secretary and Project Director, GOI), Shiv Lal (Additional DG and Director, National Institute for Communicable Diseases), D Bachani (National Project Officer for the IDSP, GOI) and project staff from the center and the Phase I states. The mission reported their findings at a wrap-up meeting, chaired by the Secretary for Health, on 10 November 04.

2. **Project launch**. The project was launched by the Minister for Health and Family Welfare of the GOI. He stressed the strong commitment of the GOI to disease surveillance and the intent to use the project to strengthen related activities across the nation. The mission recommends that this excellent launch be followed with a meeting of National Disease Surveillance Committee as early as possible.

3. **Key Project Data**

| Project Data | Project Performance Ratings | | | |
|---|---|---|---|---|
| *Board Approval:* | *Summary Ratings:* | *Last* | *NA* | *Now* *S* |
| *Effectiveness Date: October 26, 2004* | Achievement of PDO | | | |
| *Original Closing Date: September 30, 2009* | Implementation Progress | | | S |
| *Revised Closing Date (if relevant):* | Financial Management: | | | S |
| *MTR Date (Actual if completed), July 31, 2007 scheduled if not)* | | | | |
| *Original Ln./Cr. Amt: US$ 68 Million* | | | | |
| *Revised Ln./Cr. Amt:* | | | | |
| *Amount Disbursed: Nil* | | | | |
| | | | | |

Ratings: **HS**=Highly Satisfactory; **S**=Satisfactory; **U**=Unsatisfactory; **HU**=Highly Unsatisfactory; **NA**=Not Applicable; **NR**=Not Rated

[1] Members of the mission were GNV Ramana (Task Team Leader, SASHP), Mam Chand (SARPS), Mohan Gopalakrishnan (SARFM), Varalakshmi Vemuru (SASD), Kurien Thomas (Consultant) and Peter Heywood (Consultant).

## Progress so far

4. Significant implementation progress has been made in the 4 months since project Negotiations. The main items to note are as follows:

- the project was approved by Cabinet of GOI on September 17, 2004
- the project Development Credit Agreement (DCA) was signed by the GOI and the World Bank on September 23, 2004 and declared effective on October 26, 2004.
- an initial round of orientation workshops with each of the Phase I states was carried out during the months of July and August, 2004.
- the core central government project team is in place and orders have been issued formalizing the institutional arrangements.
- additional central positions have been advertised and the selection of positions will be finalized before December 31, 2004.
- selection of a procurement agent has been completed and the contract will be finalized by November 30, 2004.
- the Laboratory Manual has been finalized
- bids for provision of office accommodation for the central unit have been received and the contract will be finalized by November 30, 2004.
- the project launch workshop was held on 8-9 November 04.

## Key Issues in Implementation and Agreed Actions to Address these Issues

5. Now that implementation of the project has commenced, it is important that the pace of implementation is quickened. The main issues, which should now receive priority in the next 2 months, relate to

- initiating procurement of lab equipment, computer hardware and software, finalizing manuals, pilots for involving the private sector, commencing training activities and baseline survey on quality assurance, and
- ensuring that all phase I states sign the Memoranda of Understanding by 30, November 04 and are ready for project implementation.

## Centre

6. **Procurement**. The highest priority should be given to procurement of the lab equipment, computer software, computer hardware, and the quality assurance baseline survey. Development of software for the project is a critical and is now likely to be the limiting step. Bidding documents for hardware and Expressions of Interest (EOIs) for consultancy services, the initial steps in all these particular procurement activities, were cleared prior to project Negotiations in May 2004. It is vital that that the EOIs are now issued so that no more time is lost.

7. In the case of procurement of software development it is important that a to make a detailed assessment of the inputs, processes and outputs involved in designing and writing software for implementation of the operations manual. This is essential for technical evaluation of the bids which will be received to provide these services. This exercise will have the added value of providing a check on the internal consistency of the manual. It was agreed that the Bank would facilitate a consultation with support from Information Advisory group.

8. **Financial Management**. The draft financial manual is yet to be cleared by the Chief Controller of Accounts in the MOHFW. This manual should be finalized by 30 November 04 and issued to all states and districts. Subsequently the central unit should organize training of state financial consultants in the Phase I states as soon as they appointed (see para 15).

9. **Operations Manual**. The draft Operations Manual should now be finalized by 15, December 2004, translated into local languages by 15, January 05, and distributed to the states and districts as soon as possible. Follow-up meetings with the states should be made to benefit from initial implementation and to assess the need for any further revision.

10. **Private sector**. Involvement of the private sector is an important innovation in this project and a strategy for doing so was developed during project preparation. Meetings now need to be held with the IMA and IAP at the national level and in each state to finalize the private sector strategy and prepare and sign an MOU between the MOHFW and the national associations. The next step is to pilot and evaluate involvement of the private sector in at least 3 districts in each state. These pilots, to run for at least 4 months, should commence by 30 December 04. The mission recommends that the pilots be contracted to an experienced and qualified consultant in each province.

11. **Working Groups**. Working groups have already proven beneficial as mechanisms for obtaining broader input on various central activities. These groups are functioning for Training, Information Technology and Non-Communicable Diseases. The mission recommends that similar groups be set up for at the national level on Private Sector Involvement and Quality Assurance.

12. **Training.** Discussions between the central project unit, National Institute of Communicable Diseases staff, Indian Clinical Epidemiology Network, and representatives of Voluntary Health Association of India, World Health Organization and National Institute of Epidemiology on 9 November 04 (see detailed note in Annex 1) agreed on the following:

- that the District surveillance team training manual will be finalized during a workshop to be organized before December, 04.
- the list of training institutions (see Annex 1).
- that training will begin by January of 2005 and will include the district and state surveillance teams.

- that a Working Group member will join the first two courses in each institution to ensure quality and uniformity of the training.

13. **Non Communicable Diseases (NCDs).** An important aspect of this project is the inclusion of NCDs in the surveillance effort. The main method of surveillance used will be through periodic surveys and good progress has been under the guidance of Indian Council of Medical Research Staff. It is essential that the states are involved in the design and are responsible for implementation of these surveys. Draft protocols for the survey should be discussed with the states and sent to the Bank for review by 31 January, 2005.

**States**

14. Discussions with representatives of the 9 Phase I states to assess their implementation readiness showed the following:

- most have appointed State Surveillance Committees and District Surveillance Committees
- state surveillance officers have also been designated
- most states have established savings bank accounts for the project.

15. However, implementation is now stalled in most states due to:

- the failure to clear and sign the revised MOU sent by the central unit. Consequently, funds cannot be made available to either the states or the districts. As a result, most project activities, including appointment of contract staff, could not be undertaken.(Most states had, in fact, sent signed versions of the original MOU. However, changes required following EFC recommendation on state contribution to incremental operating costs and many states are still considering the implications of these changes. As a result, funds cannot be released to the states).
- resolution of this issue now requires high level intervention and the mission recommends that the Secretary for Health write to the various Chief Secretaries explaining the situation and requesting they expedite signing of the revised MOU.
- states are not yet clear about the procurement procedures to be used for the project. The central unit should visits all sates as soon as possible to ensure that states are familiar with the procurement procedures to be used and to resolve issues that the states feel are preventing them from implementing the project; this may require travel by the procurement officer and other staff of central unit to all the states in the near future. These state visits could also be used as an occasion on which to meet with all district surveillance officers in the state to explain project implementation.
- in some states it has not been possible to appoint suitable candidates to various contract positions, apparently because the salary levels recommended under the project are much lower than the prevailing market and salary levels in other similar projects. The states have agreed to prepare a comparison

statement by 15 December 04 for use by the central unit in an attempt to raise the salary levels to more realistic levels.

- similar changes may be necessary at the district level and states have agreed to send proposals for any changes by 15 December 04.
- states requested that the cost of staff redeployed to positions within the project should be considered as a part of the states contribution recommended by EFC. MOHFW should respond to this request by 30 November 04.

**Discussion on Training Component of IDSP**

**9 November 2004**

The Integrated Disease Surveillance Project (IDSP) is action oriented, district centered and decentralized. Human resource development is one of the important components of IDSP.

The key issues that underlie the development of the training strategy and plan for IDSP are as follows:

- IDSP does not intend to employ additional staff considering the financial position of states and long term sustainability of the project.
- Existing personnel will be provided training to undertake surveillance activities more efficiently, integrating even non-health workers for this activity.
- As far as possible, training will be provided locally at the sub-district level, some at district and small numbers at the state and central levels.
- Public private partnership is an important component of IDSP both in terms of training provider and the trainee.
- The widely used cascade method of training has not provided good quality training and this will be taken into consideration in the development of the training strategy for IDSP.

There are eight separate training programs planned under the program to meet the needs of the following groups of personnel in the program:

- Training of state and district surveillance teams
- Training of Medical Officers from PHC, CHC, urban health services and medical colleges
- Training of Medical Officers from the private sector hospitals, including SPs, MC and others
- Training of Peripheral workers – MPWs, ANMs, health supervisors, NGO field workers etc
- Training of Microbiologists and lab technicians (state and district level)
- Training of Lab technicians (sub-district level)
- Training of Data Entry Operators (State, district and sub-district level)
- Training of Data Manager

Training of state and district surveillance teams is proposed to be organized by the central unit at identified training institutions. 25 potential institutions have been identified across the country to conduct the trainings, based on the selection criteria mentioned below and eight of them will be conducting the trainings during phase-I of IDSP. The training institutes were selected as per below criteria:

- Recognized training institutions with experience in post graduate teaching in the field of community medicine/public health and microbiology;
- Adequate training infrastructure and equipment;
- Availability of resource persons in the areas of epidemiology, microbiology, medicine and paediatrics who will be resource persons for training; and
- In addition, experience in health surveillance activities.

The following table provides information on the states that will implement the IDSP in Phase-I and the institutions that will conduct the trainings.

| Sl. No | State | District | No. of trainees | Training institution |
|---|---|---|---|---|
| 1 | Himachal Pradesh | 12 | 48 | NIHFW, New Delhi |
| 2 | Uttaranchal | 13 | 52 | NIHFW, New Delhi |
| 3 | Madhya Pradesh | 45 | 180 | NICD New Delhi |
| 4 | Tamil Nadu | 29 | 116 | JIPMER, Pondicherry |
| 5 | Kerala | 14 | 56 | CMC, Vellore |
| 6 | Karnataka | 27 | 108 | CMC, Vellore |
| 7 | Andhra Pradesh | 23 | 92 | National Institute of Epidemiology, Chennai |
| 8 | Maharashtra | 35 | 140 | BJ Medical College, Pune/ Nagpur MC and Tata Institute for Social Sciences, Mumbai |
| 9 | Mizoram | 8 | 32 | AIIH&PH, Kolkata |
| **Total** | | **206** | **824** | |

The training of district surveillance teams consisting of four officers per district (District Surveillance Officer, Microbiologist, Epidemiologist and Clinician) is proposed to be organized for 206 districts (824 trainees) covered in Phase-I. Trainees per batch will be limited to 20-25 for effective training and nearly 30-35 batches will be trained in the first year of the project.

The trainings will be based on standardized modules reviewed by technical experts. The training will be six days long will be curriculum will cover the following topics:

- Introduction and overview to surveillance with special reference to IDSP
- Basic epidemiology pertaining to surveillance including definitions such as rates, ratios, Incidence Rate, Prevalence Rate, Case Fatality Rate, spot maps and graphs.

- Details of case definition, including case definitions reporting units and filling up forms, compilation and transmission of data
- Collection and transmission of laboratory specimens and bio-safety issues
- Details of analysis and interpretation of data
- Details on response to outbreaks
- Supervision, monitoring and evaluation
- Inter-sectoral collaboration

Every training will be followed by participants' feed-back that will help in evaluation of the trainings and improvement of future trainings.