INDIA

INTEGRATED DISEASE SURVEILLANCE PROJECT (Credit 3952-IN)

SECOND REVIEW MISSION

AIDE MEMOIRE

5 – 19 September, 2005

1. A World Bank team[1] reviewed the implementation progress of the Integrated Disease Surveillance Project (IDSP) during 5 to 19 September, 2005. The Bank team met with Mr. Deepak Gupta (Additional Secretary, Health and Family Welfare, Government of India (GOI)), Dr. Shivlal (Director, National Institute for Communicable Diseases); Mr. B.P. Sharma (Joint Secretary and Project Director, GOI), Dr. D Bachani (National Project Officer for the IDSP, GOI), Dr. Tarun Seem (Deputy Secretary, IDSP, GOI) and project staff from the center and the Phase I and II states. Dr. Cherian Verghese from WHO India and Mr. Christopher Barret from USAID also participated in some consultations. The Bank team also participated in a workshop to discuss the design of proposed Non Communicable Diseases survey and a field visit was undertaken to Kerala. The mission reported their findings at a wrap-up meeting, chaired by the Additional Secretary, Health and Family Welfare, on 19 September, 2005.

2. Key Project Data

Project Data	**Project Performance Ratings**			
Board Approval: July 8, 2004 *Effectiveness Date: October 28, 2004* *Original Closing Date: March 31, 2010* *Revised Closing Date (if relevant):* *MTR Date (Actual if completed), October 31, 2007* *Original Ln./Cr. Amt: US$ 68 Million* *Revised Ln./Cr. Amt:* *Amount Disbursed: US$ 6.48 Million*	*Summary Ratings*:	*Last*	*NA*	*Now* *S*
	Achievement of PDO			
	Implementation Progress			S
	Financial Management:			S

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

Key Issues in Implementation and Agreed Actions to Address these Issues

3. This is the second review mission and the project is about to complete its first year of implementation. The project continues to make progress at national level with surveillance activities getting consolidated under the National Rural Health Mission (NRHM). The Central Surveillance Unit (CSU) of the project is now co-located with the National Institute of Communicable Diseases (NICD). All Phase I states and 7 Phase II states have entered into Memorandum of Understanding with the Center. Project manuals and protocols have been developed and with in-house expertise, interim software has been prepared which allows data entry and some analysis. As agreed in last mission, most phase I states supplied one computer to each district and 3 states started using the software. The training of State and District Surveillance teams is now scheduled to be completed by October 2005. The CSU has also developed comprehensive guidelines for participation of private sector and medical colleges in disease surveillance.

[1] Members of the mission were GNV Ramana (Task Team Leader, SASHD), Isabella Danel (Sr. Public Health Specialist, LCSHH), Om Prakash (SARPS), Mohan Gopalakrishnan (SARFM), Ruma Tavorath (SASES), Kurien Thomas and Peter Heywood (Consultants)

4. While shifting of CSU will have positive impact on disease surveillance in longer run, it slowed down the implementation and some critical actions agreed before negotiations are falling behind schedule. As a result, disbursement in the project is also now significantly behind schedule and is likely to fall even further behind in the next 6 months unless a concerted effort is made to quicken the pace of implementation at the district levels, ensure that procurement of computers and software development is finalized, first round of NCD surveys are carried out, and improve pace at which the private sector is involved in the project.

5. However, it is not only the pace of implementation that is falling behind schedule. The value of the disease surveillance system depends on collecting reliable data. This, in turn, depends on the quality of the large scale training of those involved in surveillance at all levels and on the quality of laboratory procedures. It was earlier agreed that there would be an independent evaluation of the training and the quality of laboratory data. These two activities are yet to take place. There needs to be movement on these fronts as well in the next 6 months. However, their importance goes considerably beyond the benchmarking for the next mission; a satisfactory rating at the Mid Term Review (MTR) - scheduled one year from now – will be dependent on making good progress at all levels on the issues outlined above. Progress at the district level will be determined by an independent survey prior to the MTR of a sample of districts in Phase I states to assess actual performance.

Agreed Actions (Detailed Actions with dates given in Annex I)*:*

The Center will give priority to:

- Position the regional coordinators and initiate more intense monitoring of program implementation by phase I states by undertaking bi-monthly state visits
- Complete ongoing procurement actions for goods as per the revised schedule and awarding contracts for baseline survey and software development.
- Finalize selection of agencies for carrying out NCD surveys in consultation with states and initiate data collection at least in 2 states
- Evaluate training using a panel of independent experts
- Implement the external quality assurance survey

The Phase I states will give priority to:

- Position agreed staff at state and district levels by October and complete sub district and district laboratory renovations by November, 2005
- Start implementing public private partnership initiatives following the agreements reached with the professional bodies at national and state levels.
- Submit audit certificates by September and statements of expenditure by October 2005.

Implementation Progress

Component I. Establishment and Operation of Central Surveillance Unit (CSU)

6. The GOI is currently in the process of consolidating all National Health programs and critical oversight functions including disease surveillance under the NRHM. Recently, the CSU of Integrated Disease Surveillance Project (IDSP) has been moved to National Institute Communicable Diseases which will help to sustain the surveillance and disease control activities started under the IDSP. In the new arrangement, the National Project Officer continues to provide technical oversight for the IDSP under the overall guidance of Director, NICD. The Joint Secretary and the new Deputy Secretary are coordinating the program from the Ministry of Health & Family Welfare. With the appointment of the Training Consultant all approved positions in the CSU have been filled except for one data entry operator. The CSU has five working groups/technical committees to develop specific program components and recently a task force on involvement of Private Sector in surveillance has been constituted.

7. Since the May 2005 mission, the CSU completed some important activities. These include: (a) development of comprehensive guidelines for involvement of private sector and medical colleges in surveillance activities; (b) preparation of draft training module for laboratory technicians working at primary and community health centers and standard operating procedures for infection control and waste management; (c) timely release of funds to phase I states; and (d) development of an interim software using in-house expertise. The mission was informed that states of Himachal and Uttaranchal have started using the new software while Gujarat is reporting data using its existing software.

8. During the field visit the mission observed that multiple vertical disease reporting systems continue to overload the field staff and this is likely to get further pronounced with the weekly reporting envisaged under the IDSP. Many states do not have microbiologists at district level and mission recommends the states to explore different options including the possibility of hiring them on part time basis from private sector under the project. Nearly a third of sanctioned laboratory technician posts remain vacant in many states. As an initial step, it is important to optimize the existing human resources, especially the lab technicians. The center needs to take lead on this issue by promoting coordination across all disease control programs building on efforts already started under the NRHM. It was agreed that MOHFW will organize a consultation with program managers and provide appropriate guidance to states by November 2005.

9. The mission strongly endorses the MOHFW suggestion to consolidate all health sector IT services at district level with IDSP providing a platform and connectivity. The mission agrees to the proposal of MOHFW to upgrade the position of one data entry operator at district level to that of a data manager to coordinate such integration. The MOHFW will be sending a proposal to use the EDUSAT services under the project for Bank's review.

10. It was agreed that the sensitization of all stakeholders, focused training and effective use of IEC will be a key priority in this regards. Enabling community groups including Self Help Groups, youth groups, tribal organizations and Panchayat representatives to participate in disease surveillance and the system to seek this partnership would be critical. It was agreed that the Centre and States Units will design appropriate strategies. In order to guide the process, it was agreed that a Consultant Community Mobilization and IEC, will be recruited at the Central Unit.

Component II. State and District Surveillance Units

11. Surveillance officers from fifteen states (seven Phase I[2] and eight phase II[3]) attended the review meeting organized by the CSU on September 16 and 17. The review (details in annex 2) has indicated a mixed performance. The implementation continues to be satisfactory in states of Uttaranchal, Mizoram, Karnataka and Himachal Pradeh (based on reports). These states have positioned the contractual staff and data reporting has begun on pilot basis.

12. Implementation in states of Andhra Pradesh, Kerala and Madhya Pradesh continues to be slow while progress in Tamil Nadu could not be ascertained as no feedback was available from the state. Maharashtra has on going surveillance systems supported under state health systems development project and three pilots (medical college involvement, urban surveillance and public private partnerships) supported by USAID. The real challenge for this state is to integrate these activities and plan for strengthening disease surveillance activities in Mumbai which recently experienced a major outbreak of Leptospirosis. A detailed field visit report from Kerala highlighting the operational issues is presented in Annex 3.

13. A factor contributing to the delayed implementation was the perception in some of the states that project launch is necessary for beginning the activities. The MOHFW clarified to all states that launch is a formality and project activities should start as per the agreed schedule. Some phase I states are yet to release funds to districts. To facilitate decentralized need based procurement of lab consumables, the MOHFW has agreed to send guidelines to states on items that could be purchased and procedures that need to be followed. It was clarified that the state could undertake emergency purchase of testing kits for state specific diseases included in the approved plans following agreed procedures informing the CSU. It is important to have quality human resources at the State Surveillance Units (SSUs) and the mission recommends higher remuneration (up to Rs. 25,000) to the consultants hired at state level.

14. From the field visit the mission notes the requirement for special surveillance activities in urban areas, especially metro-cities. It was agreed that MOHFW will organize a one day consultation for the piloting integrated urban disease surveillance in 4 metro cities (Chennai, Delhi, Kolkata and Mumbai). This consultation could be organized in Pune where urban surveillance program is being implemented with USAID support.

15. Among the 14 Phase II states, 7 have submitted implementation plans and signed memoranda of understanding with the center and 3 states have shared their implementation plans. The remaining 4 states[4] are lagging behind and MOHFW has agreed to follow-up with them with the support of Indiaclen group that has been supporting this activity.

16. It is critical that the phase I states appoint staff as soon as possible and start implementing surveillance activities. The specific dates agreed for completing these actions are listed in annex II. It was agreed that during next review mission a decision on dropping states that failed to achieve these agreed benchmarks from the program will be taken. Implementing effective disease surveillance activities at district level is most important outcome envisaged under the project and this will be assessed in a sample districts for the project mid term review.

Component III. Improving Laboratory Support

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[2] Andhra Pradesh, Karnataka, Kerala, Madhya Pradesh, Mizoram, Maharashtra, and Uttarnchal,
[3] Chattisgarh, Chandigarh, Pondicherry, Haryana, Gujarat, Goa, Orissa and Rajasthan
[4] Tripura, Meghalaya, Delhi, Pondicherry

17. The laboratory renovation continues to be slow in Phase I states, except for Uttaranchal. It was agreed that all phase I states would ensure completion of laboratory repairs by November 30, 2005. The MOHFW clarified that these resources are meant for filling the critical infrastructural gaps in the existing public health laboratory network. The states will have flexibility to use these funds for strengthening L1 (PHC/CHC) and L2 (district public health lab) based on actual need.

18. The agreed action to award contract for External Quality Assurance Survey (EQAS) could not progress as none of the agencies that responded for the baseline survey had capability to undertake such survey. For carrying out EQAS, very specialized skills are required and very few agencies have such skills and proven expertise. Taking this in to consideration, the MOHFW proposed to engage 4 institutions covering different regions of the country (Southern Region: Christian Medical College, Vellore; Western and central region: National Institute of Virology, Pune; Northern region: National Institute of Communicable Diseases, Delhi; and Eastern Region: National Institute of Cholera and Enteric Diseases, Kolkata).

19. While agreeing with this suggestion in principle, the mission requested a formal communication from MOHFW providing justification for single source with estimated value of consultancy. The mission also clarified that 3 out of 4 institutions proposed by MOHFW are dependent agencies and hence will be eligible only for reimbursement of incremental costs. To move forward on this process, it was agreed that the MOHFW will identify one nodal agency among the these 4 institutions to develop terms of reference and detailed protocol including analysis plan. The MOHFW will organize a work shop to finalize the protocols and agree institutional arrangements for implementation. The survey will begin from December 2005 and first quarter results will be available for the next mission scheduled in February 2006.

Component IV. Training for Disease Surveillance and Action

20. Training of district and state surveillance teams is progressing and till date 16 batches have completed training. Trained staff from these teams will be the core trainers for the decentralized training of medical officers and para-medical staff. Therefore, ensuring high quality of this training is critical for the entire IDSP. The training institutes were selected based on their past track record and it is important to assess their effectiveness in IDSP training. The agreed external evaluation on the current training program is still pending.

21. Feed back from some state surveillance officers suggests that the training sessions were very theoretical and did not reach up to expectations. The feedback at the recent epidemiology week also highlighted the need for standardizing content and making this training more participatory. It is very important to evaluate this training by competent experts and incorporate appropriate changes in the training protocols based on the feedback received. There is also need to provide a separate trainers manual and power point presentation and training aids including case studies, role plays etc. to improve quality and uniformity of the training.

22. External evaluation must be initiated without any further delay. The evaluators would need adequate competency for carrying out training assessments as well as a good understanding of the IDSP. Since adequate number of experts with such skills may not be available in one institution, the mission recommends that a panel of about 10 external experts be constituted by MOHFW including 5 members from Teacher training centers (BHU, Varanasi; PGI, Chandigarh; AIIMS, Delhi and St.Johns, Bangalore) along with 5 additional consultants with a good understanding of IDSP. This panel could be given the responsibility to quickly undertake training evaluation over the next 2 months and submit a report by end

December 2005. Costs of this consultancy including consultant fee, travel and office support could be met from the project.

23. Detailed planning for down stream training of Medical officers, Lab Technicians and Health workers has not been initiated by the states. This must be done at the earliest and program initiated in the districts where Level-1 trainers have come back after completion of training. The CSU has agreed to provide guidance note to the states in preparing such plans. There is need to translate health worker manual to local languages.

Private Sector Participation

24. Public private partnerships are critical for the success of integrated disease surveillance in India. The strategy laid down by Central Surveillance Unit will succeed only if the states and districts are able to implement it in a timely and effective manner. Voluntary partnership and not mandatory reporting is key to the success of this partnership. State visits and discussions with the State nodal officers revealed that there has not been much progress in implementation at the state and district levels.

25. As a first step towards this, the CSU and State Surveillance Units (SSUs) should enter in to memoranda of understanding with two important professional bodies, the Indian Medial Association (IMA) and Indian Academy of Pediatrics (IAP) which have strongly endorsed this initiative. Involvement of private medical colleges in disease surveillance is also important following the guidelines developed by the CSU. It was agreed that this strategy would be implemented in a phased manner starting with 15-20 sentinel sites per district in the first year and doubling this number over the next 2 years. Sensitization workshops must be organized to orient the participating sentinel units to function effectively. In addition to sentinel surveillance, the strategy for public private partnership should also include approaches for collecting information from a wide range of formal and informal private health providers such as pre-paid cards, telephone, fax etc. This must get incorporated in the data base by geographical location to facilitate action. The mission recommends a formal evaluation of the public private partnership in a sample districts for the project mid term.

Surveys for Non Communicable Diseases (NCDs)

26. This is an important component of the IDSP. Since the last supervisory mission little progress has been made in implementing the NCD risk factor survey. The Technical Working Group headed by ICMR has completed survey design, methodology including sampling, draft questionnaire and a training manual for field workers. However, states have not been involved in the process, agencies for carrying out the survey have not been selected, and field work still seems a long way off. This is mainly due to lack of a focal point to effectively coordinate all these activities.

27. It was agreed that an NCD surveillance cell will be created within CSU to coordinate and manage the NCD risk factor surveys in close consultation with states. As recommended by the ICMR team, this cell will have a technical expert supported by a team consisting of data manger, social scientist, statistician and support staff. Positioning this team during the next two months would be a top priority. The goal would be to work with the Phase 1 states and ensure that NCD surveys begin in at least two states by November 2005. The NCD surveillance cell will need to work closely with NCD program cell and the states to ensure use of the information from the surveys to develop and implement interventions to promote health and prevent NCDs.

28. The mission discussed a range of issues with the Technical Working Group. The CSU shared the protocol with states during the review meetings and sought their feedback. All states strongly endorsed the need for such surveys and wanted inclusion of bio-chemical risk

factors. It was agreed that if there is no state, para-state, or academic agency with expertise in conducting surveys, services of a market agency will be considered. Without burdening the service delivery, local health workers will be involved facilitate referrals for people with abnormal findings (e.g. hypertension). It was also agreed that the NCD cell in consultation with the ICMR will develop a quality assurance protocol for the surveys including an assessment of inter-observer variation. It is important for each state to develop a utilization plan for the results from the survey involving a variety of organizations (academics, professional bodies, interest groups etc.) working in the NCD field. The CSU has agreed to organize one day consultation in October 2005 to finalize implementation arrangements of NCD surveys.

Procurement

29. Since Project became effective in October 2004, contracts against procurement under ICB initiated in the first year of the Project could not be awarded in FY 2004-05. The Mission was informed that bids for (i) Binocular Microscopes and (ii) Autoclaves, Hot air ovens & Bio Safety Hood called under ICB were opened in April 2005. These bids are under evaluation and contracts are expected to be awarded by end October 2005. NCB bids for the laboratory equipments (a) -70º C Deep Freezer, (b) -20º C Deep Freezer, and (c) Elisa Reader & Washer were opened in August 2005 and contracts will be awarded by mid November 2005. NCB bids for office equipments have also been opened in September 2005 and award of contracts is expected by mid November 2005. Based on the initial review of bids received the CSU is estimating a saving of about Rs.70 million equivalent in the laboratory equipment.

30. CSU had short-listed firms for inviting proposals for development and implementation of software for which no objection was provided by Bank on June 20, 2005. The draft RFP, presently under review by the Bank, was discussed with the CSU Team. The Mission was informed that certain clauses (Para 1.7.1 of Information to Consultants) relating to the conflict of interest may not be acceptable to the firms, because some of the short-listed firms are also manufacturers of hardware and these clauses will disqualify them from bidding for supply of the hardware. The mission clarified that the standard conditions of the RFP can not be relaxed and that the CSU may consider obtaining re-confirmation from the short-listed firms about their continued interest in providing services as per provisions of the RFP. Present status of procurement of (i) goods, and (ii) services planned for the year 2005-06 is given in attached Annexure IV.

Financial Management

31. The CSU has advanced an amount of Rs 434 million to the various States (Rs 239 million till March 31, 2005 and Rs 195 million till Sept 5, 2005 in financial year 2005-06). The GOI records these transfers as expenditure but for the purpose of the project these are recognized as advances only. The budget for the year 2005-06 is Rs 880 million. The expenditure incurred till March 31, 2005 was Rs 3.083 million. Thus, a large amount of funds are lying as advance with the States. The mission also noted that funds released to States are earmarked for specific activities as opposed to block grant against approved annual work plans, which reduces the flexibility available to the States. The MOHFW has agreed to send a communication to states clarifying this.

32. While the finance function is fully staffed at the CSU and the financial management manual has been approved and printed, the finance positions in only five out of the nine phase I states have been filled in, while the other four are in the process of completing the recruitment process. Phase II States have yet to initiate the process of appointment. As a significant amount of funds have started flowing to the States it is necessary that the finance positions are filled in at the earliest. The lack of finance staff is being reflected in financial reports/SoE's not being submitted by any of the Phase I states for the first quarter of the

financial year 2005-06. The Phase II States have also identified the Society at the State level which would be responsible for all financial management aspects, but the evaluation checklist has not been completed, which was a pre-requisite prior to selection. The audit report for the central level expenditure is due by Sept 30, 2005 (as per the TOR consented to by the CAG). The six monthly FMR for the period ended March 31, 2005 was submitted, with some delays and the FMR for the period ending Sept 30, 2005 is due by November 15, 2005.

Environment Plan

33. As per the Environmental Management Plan, developed under the project, the CSU has to undertake a baseline assessment, develop Standard Operating Procedures (SOPs), and formulate a Waste Management plan during the first year of project implementation. The mission is pleased to note that two of the above activities are well underway. CSU is in the process of recruiting an agency to undertake baseline survey of Laboratory Services, covering all components of laboratory functioning, including bio-safety and waste management practices. This survey is expected to be completed by December 2005. The Training Consultant has developed a Bio-safety manual, in consultation with NICD. The manual focuses on Infection Management, worker safety and waste management and is designed to be a reference guide for all levels of laboratories. The manual, which is still in draft, will be sent to the Bank for review, before finalization. It was discussed and agreed that the bio-safety manual will be incorporated with the training manuals for Laboratory Technicians. The mission recommends that the bio-safety manual be incorporated with the Operations Manual for District Surveillance Units and the Training Manual for State and District Surveillance Officers (also referenced in para 27 of earlier Aide-memoire dated 25 April 2005).

Annex I

Agreed Actions for Next Six Months

Agency Responsible	Action	By when
Central Surveillance Unit	• Strengthen monitoring of project implementation by Phase I states by positioning regional coordinators and institute a mechanism of regular state visits by the designated CSU staff • Appoint staff on contract for the NCD and IEC/Social mobilization cells	October 31, 2005
	• Award contract for baseline survey • Finalize the protocol and start implementing External Quality Assurance Survey (EQAS)	October 31, 2005 November 30, 2005
	• Organize a consultation to finalize the design and implementation arrangements for carrying out Non Communicable Disease surveys and start data collection in two states	November 30, 2005
	Complete training for using the interim software to states with essential inputs in place • Phase I states • Phase II states	 November 30, 2005 March 31, 2005
	Complete independent external evaluation of training program	December 31, 2005
	Update medical officers manual to include local responses for outbreaks for different diseases	November 30, 2005
	Award all contracts for • laboratory and office equipment for year I, • Software development • Computer hard ware	 November 30, 2005 December 31, 2005 January 31, 2006
	Finalize strategy and implementation arrangements for private sector participation in disease surveillance and sign memorandum of understanding with Indian Medical Association and Indian Academy of Pediatrics	October 31, 2005
	Provide guidance to states on integrated use of available human resources for disease surveillance, organization of decentralized training activities, and procurement of laboratory consumables	October 31, 2005
	Organize a consultation for 4 metro cities to develop proposals for integrated disease surveillance urban areas	December 31, 2005
	Share the FMR for the period ended Sept 30, 2005	October 31, 2005
	Share audit report for the central level expenditure (as per the TOR consented to by the CAG)	September 30,2005
State Surveillance Units	Finalize training plans for decentralized training of medical officers, para medical staff and sensitization workshops for other key stakeholders	October 31, 2005
	Position all staff at state and district levels as per their implementation plans • Phase I states • Phase II states	 October 31, 2005 December 31, 2005
	Complete renovation of the district public health laboratories ensuring physical integration of district malaria and TB labs	November 30, 2005
	Phase II states to submit FM Checklists for identified Society	November 30, 2005

Annex II

State Review Summary

Checklist for Monitoring of States (Phase-I)
□ = Yes; X = No; □ = Under Process

S.No.	*Parameters*	*HP*	*Uttra*	*Mizo*	*MP*	*Maha*	*Kar*	*AP*	*TN*	*Ker*
1	**Organizational Structure**									
1.1	Constitution of State Surveillance Committee	□	□	□	□	□	□	□	□	□
1.2	Setting up of State Surveillance Unit	□	□	□	□	□	□	□	□	□
1.3	Constitution of District Surveillance Committee	□	□	□	□	□	□	□	□	□
1.4	Setting up of District Surveillance Unit	□	□	□	□	□	□	□	□	□
1.5	MoU Signed and sent to CSU	□	□	□	□	□	□	□	□	□
1.6	Identification of State Society for funding	□	□	□	□	□	□	□	□	□
2	**Human Resources**									
2.1	**Incremental staff at State Level**									
2.1.1	State Surveillance Officer Designation	□	□	□	□	□	□	□	□	□
2.1.2	Consultant - Technical & Training	□	□	X	□	□	□	□	□	□
2.1.3	Consultant - Finance & Procurement	□	□	□	□	□	□	□	□	□
2.1.4	Data Manager	□	□	□	□	□	□	□	□	□
2.1.5	Data Entry Operators (2)	□	□	□	□	□	□	□	□	□
2.1.6	Accountant	□	□	X	□	□	□	□	□	□
2.1.7	Office Assistant	□	□	□	□	□	□	□	□	□
2.1.8	Class IV	□	□	□	□	□	□	□	□	□
2.2	**Incremental staff at District Level**									
2.2.1	District Surveillance Officer	□	□	□	□	□	□	□	□	□
2.2.2	Data Entry Operators (2)	□	□	□	□	□	□	□	□	□
2.2.3	Accountant	□	□	□	□	□	□	□	□	□
2.2.4	Administrative Assistant	□	□	□	□	□	□	□	□	□
3	**Training**									
3.1.1	Identification of State/Distrrict Surveillance Teams	□	□	□	□	□	□	□	□	□
3.1.2	Intimation of list of trainees to training institution	□	□	□	□	□	□	□	□	□
3.1.3	Training calendar (specify dates)	□	□	□	□	□	□	□	□	□
3.1.4	No. of trainees trained till date	**40**	**29**	**26**	**45**	**59**	**30**	**20**	□	**20**

S.No.	*Parameters*	*HP*	*Uttra*	*Mizo*	*MP*	*Maha*	*Kar*	*AP*	*TN*	*Ker*
3.2	**State & District Level**									
	Plan for State & District level training prepared for									
3.2.1	Medical Officers	□	□	□	X	X	□	X	□	□
3.2.2	District Laboratory technicians	□	□	X	X	X	□	X	□	□
3.2.3	CHC/PHC Lab.technicians	□	□	X	X	X	□	X	□	□
3.2.4	Health Workers	□	□	□	X	X	□	X	□	□
3.2.5	Accountants	□	□	□	X	X	□	X	□	□
3.2.6	Data Entry Operators	□	□	□	X	X	□	X	□	□
4	**IT & MIS Activities**									
4.1	**Procurement of IT hardware (NS)**									
4.1.1	Pentium IV purchased and installed	□	□	**9**	□	X	**28**	□	□	**15**
4.1.2	Printer & UPS	□	□	**9**	□	X	**28**	□	□	**15**
4.1.3	MS Office Professional	□	□	**9**	□	X	**28**	□	□	**15**
4.2	**Data Collection & Reporting at District level**									
4.2.1	Data Collection Forms delivered and printed	□	□	□	X	X	□	X	□	X
4.2.2	Data Collection Activity started	□	□	X	X	X	□	X	□	□
4.2.3	No. of Districts where Private Sector initiated	□	**2**	X	X	X	**27**	X	□	**14**
4.2.4	Data Entry on Software	□	□	X	X	X	X	X	□	X
4.2.5	Report Generation & Analysis	□	□	X	X	X	□	X	□	X
4.2.6	Data/Report Transmission to State/Central Units	□	X	X	X	X	□	X	□	□
5	**Procurement of Goods & Services**									
5.1	**Renovation & Furnishing of Laboratories**									
5.1.1	State Surveillance Unit	□	□	□	X	□	□	X	□	□
5.1.2	No. of District Surveillance Units covered	□	**13**	□	X	□	□	X	□	□
5.1.3	No. of District labs. Covered	□	**13**	□	X	□	□	X	□	□
5.1.4	No. of peripheral labs. Covered	□	**23**	□	X	□	□	X	□	□
5.2	**Procurement of goods for Laboratories**									
5.2.1	List of consignees sent For central purchase	□	□	□	□	□	□	□	□	□
5.2.2	Procurement of lab equip. & supplies by NS	□	X	□	X	X	□	X	□	X

S.No.	*Parameters*	*HP*	*Uttra*	*Mizo*	*MP*	*Maha*	*Kar*	*AP*	*TN*	*Ker*
6	**Financial Status (Amount in Rs.million)**									
6.1	**State Surveillance Unit**									
6.1.1	GIA from Central level (2004-05 & 2005-06)	**17.40**	**9.00**	**18.27**	**54.91**	**57.00**	**42.14**	**39.16**	**53.98**	**15.68**
6.1.2	Grant released to districts (2004-05 & 2005-06)	□	**6.69**	**4.09**	X	X	**0.75**	□	□	X
6.1.3	Expenditure incurred	□		**1.83**	**0.08**	**0.12**	**2.89**	□	□	**1.20**
6.1.4	Annual Audit Certificate (2004-05)	□	X	□	X	X	□	X	□	X
6.1.5	Utilization Certificate (2004-05)	□	X	X	X	X	□	X	□	X
6.1.6	Submitted Budgetary Reuirement for 2005-06	□	□	□	X	X	□	X	□	X
6.2	**District Surveillance Units**									
6.2.1	No. of Districts receiving GIA (2004-05 & 2005-06)	□	**13**	**9**	X	X	**27**	X	□	X
6.2.2	No. of Dists. reporting expenditure (04-05, 05-06)	□	X	**9**	X	X	**27**	X	□	X
6.2.3	No. of Districts where accounts audited (2004-05)	□	X	X	X	X	□	X	□	X
6.2.4	No. of Districts submitted UC for 2004-05	□	X	X	X	X	**27**	X	□	X
6.2.5	No. of Districts submitted Budgetary req. 05-06	□	**13**	**9**	X	X	**27**	X	□	X

Annex III

Kerala State Visit Report
September 7-9, 2005

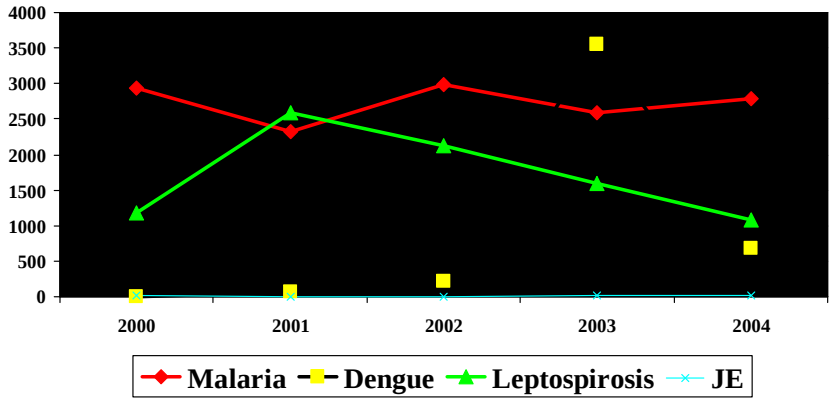
Background:

A joint Government of India and World Bank mission visited the state in September 2005 to review the implementation progress of Integrated Disease Surveillance Project (IDSP) in September 2005. There are two main reasons for visiting Kerala. First, to learn from experiences of daily outbreak reporting system that was established by the state. Second, to discuss the implementation issues with the senior state officers and evolve an action plan to improve IDSP implementation in the state.

The team met with Honorable Minister of Health Mr. Ramachandaran Master; Mr. C. Ramachandran, Additional Chief Secretary, & Principal Secretary (Health); Dr. Mahilomani, Director Health Services, Dr. Meenu Hariharan, Director Medical Education, Dr. Jeevan, Additional Director and state surveillance officer and other senior staff. A field visit was undertaken to Community Health Center, Vithura followed by interactions with district medical officer of Thiruvananthapuram, staff of state public health laboratory and epidemiology cell located at the Directorate of Health Services.

Epidemiological situation:

Trends of major communicable diseases in Kerala
2000-04



1. Kerala state has made a phenomenal progress in improving health outcomes. Despite significant progress made in control of communicable diseases, the state experienced serious outbreaks of Leptospirosis and Dengue in 2001 and 2003 respectively with each of these diseases contributing to about 3000 cases and 100 deaths. The state experiences sporadic outbreaks of jaundice and diarrhea, and is known to be endemic for Filaria. About 3000 cases of Malaria are reported every year mostly in urban areas and about 25% of them are due to Falciparum. The outbreaks of Leptospirosis and Dengue prompted the state to establish a daily reporting system to monitor outbreaks of 9 diseases.

2. With increased expectancy of life, the burden of non communicable diseases has increased. The state has unique data on risk factor prevalence from ongoing cohort studies. In addition, non communicable diseases treated by the public health facilities are complied. However, there is no state-wide population based data on prevalence of risk factors for non-communicable diseases.

Issues:

These observations are based on limited field visits and interactions with the staff during the visit

1. *Use of surveillance data at local level*. The state has established a good daily information collection on outbreaks of 9 communicable diseases and other infectious dieses from over 1200 public health institutions spread all over the state. Participation of Private sector is however limited in this activity. The mission is very impressed to note the effort that gets into compilation of this information every day through telephone calls and upward reporting of data. However, the use of this information at local and district levels for decision making appears to be limited. This is partly due to lack of adequately trained staff to monitor trends and interpret the data. At the state level, some good measures such as establishment of inter-sectoral coordination committees, regular visits to panchayats reporting outbreaks, feedback to the district health officers on control measures, supply of pharmaceuticals and standard treatment guidelines are being done.

2. *Integrating disease surveillance activities.* It appears that there is not much of a strategic vision to integrate and streamline surveillance activities in the state. For example, there are multiple information systems that were simultaneously operating with little coordination and sharing of information. These include, daily epidemic reporting system led by state epidemiology cell, weekly reporting of 23 diseases led by statistics units, vector borne diseases surveillance, TB case reporting and child hood disease reporting in RCH.

3. *Importance of strengthening surveillance in urban areas*. The available data suggests concentration of some outbreaks in urban areas. Like other Indian states, the surveillance activities in larger cities are generally weak in Kerala and collection of information from private sector, which is an important source of care, is inadequate. Participation of Municipalities/Municipal Corporations is also a limiting factor.

4. *Partnership with Private Sector*. Like many other states, private sector is an important provider of curative services in Kerala. The current epidemic reporting system collects data from private sector during outbreaks and generally there is no feedback to private sector.
5. *Need for population based data on NCD and improved road traffic accident surveillance*. As planned under the IDSP, it is important to gather data on risk factor prevalence of non-communicable diseases at regular intervals. Similarly, information on road traffic accidents from different sources needs to be compiled to assess the burden.

Way forward.

1. It is important to strengthen the capacities at CHC and district levels to analyze the data and take local actions to control communicable diseases. The training of the district surveillance teams and medical officers need to focus on this aspect. With the rich experience and data available in the state in the control of Leptospirosis and Dengue, it would useful to document them in the form of case studies.
2. There is need to undertake more intensive epidemiological investigations in to factors contributing to outbreaks of Leptospirosis and Dengue in the state and the effectiveness of current intervention measures. The state has highly competent professionals in the clinical epidemiology units of medical colleges and Achyuta Menon Center. Services of such experts could be used by the state epidemiology unit for such detailed assessments.
3. Developing a more comprehensives urban disease surveillance strategy in partnership with the private sector and piloting one city during the next year would be useful and the state could seek support for such initiative under the IDSP.
4. The state has pioneered good private public partnerships in TB program and it is important to build on this relationship to involve private sector in disease surveillance activities following the overall framework of IDSP. Training of lab technicians in private sector, and collecting data on regular basis from identified sentinel centers which are more likely to treat the epidemic prone diseases need to be explored.
5. The GOI is finalizing the protocols for population based assessment of risk factors for non communicable diseases and models for surveillance of road traffic accidents. Considering the high burden of NCDs, Kerala needs to implement them on a priority basis to enable the state to develop and implement of state specific approaches to control non-communicable diseases and road traffic accidents, and monitor their effectiveness

IDSP Implementation.

Issue	Agreements reached
Slow Project implementation due to linking all project activities to launch of the project	To de-link project implementation with launch. Formal Project launch in early October immediately after the ongoing local body elections. At the project launch the following activities will be undertaken: • all district surveillance teams would be introduced the project concepts and new data reporting schedules would be shared • sensitization of key players of the Private sector in the State • training for accountants on book keeping and data entry operators on using the interim software.
Position of contractual staff supported by the project delayed. Selections completed	All contractual staff will be in position by 15 October 2005

at district level and still to be completed at state level	
Separate account for IDSP	To be opened by 1st October 2005 and funds under IDSP transferred to the new account
Non availability of microbiologists/pathologists at district level	State will map microbiologists from private medical colleges/private hospitals/labs by September 30, 2005 and use their services on part-time basis for the program.
Shortage of program managers at district level	As per the MOU, the state will ensure one officer designated as district surveillance officer
The state and regional public health laboratories are essentially providing clinical services	The state will evolve a strategy for strengthening the role of state and regional public health labs in IDSP and share with GOI by October 31, 2005. Some such activities include: • in-service training of laboratory technicians, • quality assurance and • epidemic outbreak investigations • detailed analysis of trends in clinical cases.
Private Sector Involvement	Combined sensitization workshop during state launch followed by regional workshops by IMA

Annex

Reported Epidemiological Data on major communicable diseases in Kerala 2000-2005

Year	Malaria		Dengue		Leptospirosis		JE	
	CASE	DEATH	CASE	DEATH	CASE	DEATH	CASE	DEATH
2000	2940	9	0	0	1174	87	11	1
2001	2331	9	66	1	2582	119	2	0
2002	2986	8	219	2	2128	181	1	0
2003	2586	7	3546	68	1596	124	14	0
2004	2790	12	686	8	1082	96	11	0
2005*	860	2	800	7	916	77	1	0

*2005 data up to 6, August 2005

Diseases included in daily reporting from over 1200 institutions:

1. Leptospirosis
2. Dengue
3. Cholera
4. Malaria
5. Typhoid
6. Viral Hepatitis A
7. Viral Hepatitis B

8. Viral Fever
9. Acute Diarrheal Diseases
10. Other communicable Diseases

Diseases included in weekly and monthly reporting of cases and deaths from all public health facilities by sex, source of treatment – Out Patient or In Patient

1. Acute diarrhea diseases
2. Diphtheria
3. Acute poliomyelitis
4. Tetanus other than neonatal
5. Neonatal Tetanus
6. Whooping Cough
7. Measles
8. Chicken pox
9. Acute Respiratory Infection (excluding Pneumonia)
10. Pneumonia
11. Enteric Fever
12. Dengue Fever
13. Viral Hepatitis A
14. Viral Hepatitis B
15. Leptospirosis
16. Japanese Encephalitis
17. Meningococcal Meningitis
18. Rabies
19. Syphilis
20. Gonococcal Infection
21. Pulmonary Tuberculosis
22. Guinea Worm
23. Anthrax
24. All other diseases

Annex- IV

Integrated Disease Surveillance Project: Procurement of Goods for Year – 2005-06

Status Report

SN	Item & Quantity	Type of Procurement	Estimated Price (Rs Million)	Status	Next Action
1	Supply of 250 Binocular Microscopes	ICB	50.00	Bids opened on April 26, 2005	Bid evaluation under process. Award of contract by end of Oct 05.
2	Supply of 108 each Autoclaves, Hot Air Oven and Bio Safety Hoods	ICB	43.20	Bids opened on April 27,2005	Bid evaluation under process. Award of contract by end of Oct 05.
3	Supply of 10 Elisa Reader and Washer	NCB	3.50	Bids opened on August 30,2005	Bid evaluation under process. Award of contract by mid November 05.
4	Supply of 10 Minus 70 degree centigrade Deep Freezers and 108 minus 20 degree centigrade Deep Freezers	NCB	12.80	Bids opened on August 25,2005	Bid evaluation under process. Award of contract by mid November 05.
5	Supply of minor instruments and equipments	NS	137.01	To be procured by States/Districts.	Quarterly Progress to be reported by States. First review in mid September 05 during Review meeting of Nodal Officers from States.
6	Supply and installation of computer hardware with operating system on clients	ICB	246.12	Deferred to next year as specifications would be based on the recommendations of software consultants.	
7	Supply and installation of Operation Systems for Servers, RDBMS, Website tools and GIS software	ICB	70.22		
8	One PC,UPS & printer for each district & SSU proposed on DGS&D rates and approved by WB for starting Pilot Surveillance till main package is ready	NS	10.75	To be procured by States/Districts	Quarterly Progress to be reported by States. First review in mid September 05 during Review meeting of Nodal Officers from States.
9	Supply of 215Photocopiers,221 fax machines and 2 large copiers	NCB	14.46	Bids opened on September 1,2005	Bid evaluation under process. Award of contract by mid November 05.
10	Supply of 217 overhead projectors nd 11 LCD projectors	NCB	3.82	Bids opened on September 8,2005	Bid evaluation under process. Award of contract by mid. November 05.
11	Telephones and air conditioners	NS	22.99	To be procured by States/Districts	Quarterly Progress to be reported by States. First review in mid September during Review meeting of Nodal Officers from States.
12	Supply of 286 Typhoid rapid diagnostic kits,1433 kits for faecal contamination and 678 HIV Elisa diagnostic Kits	NCB	3.87	Will be tendered by end of September 05.	
13	Supply of laboratory reagents, chemicals and consumables	NS	26.00	To be procured by States/District	Quarterly Progress to be reported by States. First review in mid September 05 during Review

Annex V

Integrated Disease Surveillance Project: Procurement of Services for Year I
Status Report

SN	Item and Quantity	Type of Procurement	Estimated Price (Rs Million)	Status	Next Action
1	Hiring services of procurement Agent	QCBS	25.00	GOI has appointed Hospital Services Consultancy, a dependent agency and the consultancy fee will be paid from the domestic budget.	Procurement agent to provide monthly progress report to MOHFW and half yearly status report to Bank before review mission.
2,3, 4	Contractual Staff at district (824),State (63) and central (15) levels	Individual /service delivery contracts	51.00	All contractual staff in position at central level, except one. Contractual staff appointed in H.P and Mizoram in advanced stage in Karnataka and Uttaranchal.	GOI will provide a status report by June 30,2005 and then onwards report quarterly progress.
5	Consultancy for development of application software	QCBS	75.00	Good response to EOI. 6 consultants Short-listed.	To issue RFP after obtaining clearance of draft RFP from Bank.
6	Hiring agency for media buying and press releases	QCBS	6.95	QCBS	
7	Press releases/advertisement s at district/ state levels	Least Cost	4.86	To be procured by States/Districts.	GOI will provide a status report by June 30, 2005 and Quarterly Progress to be reported by States. First review in mid September 05 during Review meeting of Nodal Officers from States, then onwards report quarterly progress.
8	Printing of IEC material at district/state levels	By calling 3 or more proposals	4.96	To be procured by States/Districts.	-do-
9	Procurement of other media including indigenous methods	Single source	4.12	To be procured by States/Districts.	-do-
10	Baseline survey for Bio-Safety	QCBS	1.05	EOI received good response.	Short listing under Process.

11	Survey for risk factors of Non Communicable Diseases	QCBS	6.00	Sampling frame finalized	To develop TOR for survey agencies by June 30, 2005. Process of identification of institutions for NCD risk factors surveillance has been initiated.
12	Hiring of institutions or training (a) district surveillance teams (b) lab technicians and (c) data managers	QBS	9.44	8 institutions selected for training District surveillance teams.	To identify remaining institutions and complete the training of District surveillance teams by August 2005.
13	Training of medical Officers by district surveillance teams	Individual	19.99	To be procured by States/Districts. This activity will not be outsourced.	GOI will provide a status report by June 30, 2005 and then onwards report quarterly progress. First review in Mid September during Review meeting of Nodal Officers from States.
14	Training of MPW and lab assistants by selected CHC's		53.41	-do-	-do-