

**Research Study on ‘ Effectiveness of Panchayati Raj Institutions (PRIs)  
in Health Care System: Impact of Duality and role of bureaucracy in new  
approach-in the State of Karnataka”**

*Study Conducted by*

**iDpms**

MAKING A DIFFERENCE  
TO THE RURAL POOR

BANGALORE

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नीति आयोग  
National Institute for Public Policy

**The Research Division,  
NITI Ayog,  
Government Of India**

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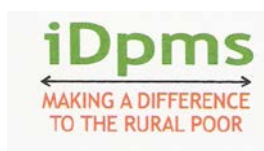
**Sponsored by : THE RESEARCH DIVISION, NITI AYOJ,  
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## ABBREVIATIONS

AMG	- Annual Maintenance Grant
ANM	- Auxiliary Nurse Midwife
ARS	- Arogya Raksha Samithi
ASHA	- Accredited Social Health Activist
CAO	- Chief Accounts Officer
CEO	- Chief Executive Officer
CHC	- Community Health Centre
CNA	- Community Need Assessment
CPO	- Chief Planning Officer
CR	- Confidential Report
DHO	- District Health Officer
DOT	- Directly observed treatment (TB)
DPMO	- District Planning & Monitoring Officer
EO	- Executive Officer
FRU	- First Referral Unit
GP	- Gram Panchayat
HESC	- Health and Education Standing Committee
HMC	- Hospital Management Committee
IEC	- Information, Education and Communication
IMR	- Infant Mortality Rate
JE	- Japanese Encephalitis
JSY	- Janani Suraksha Yojana
KDP	- Karnataka Development Program
KHPT	- Karnataka Health Promotion Trust
KPRA	- Karnataka Gram Panchayat Act, 1993
KRWSSA	- Karnataka Water Supply and Sanitation Agency
LHV	- Local Health Volunteer

MMR	- Maternal Mortality Rate
MMU	- Mobile Medical unit
MO	- Medical Officer
NMR	- Neo Natal Mortality Rate
NREGA	- National Rural Employment Guarantee Act
NRHM	- National Rural Health Mission
OPD	- Out Patient Department
PDO	- Panchayat Development Officer
PHC	- Primary Health Centre
PRI	- Panchayat Raj Institution
RCH	- Reproductive and Child Health
RFS	- Rheumatoid Factor Study
RKS	- Rogi Kalyan Samithi
SC	- Sub Centre
SDMC	- School Development Monitoring Committee
TB	- Tuberculosis
TFR	- Total fertility Rate
THO	- Taluk Health Officer
TMO	- Taluk Medical Office
VHSC	- Village Health Standing Committee

## EXECUTIVE SUMMARY

By bringing into effect the Karnataka Zilla Parishads, Taluk Panchayat Samitis and Mandal Panchayats and Nyaya Panchayats Act in 1987, Karnataka became a path breaker in decentralized governance. It compelled the Union Government to bring in 73<sup>rd</sup> Amendment to Constitution of India. Following the guidelines set in the amendment, in 1993 Government of Karnataka brought into effect the Karnataka Panchayat Raj Act. Karnataka was one of the few states, which transferred all the 29 subjects to the PRIs. The Act hoped to soften the restrictions and limitations in implementation of various schemes as per the departmental guidelines. Based on the principle of subsidiarity, duties and functions were assigned to the three tiers in three different schedules. However there were overlapping of duties and functions. In order to remove overlapping, amendment was made to KPA 1993 in 2003 and revised schedules were framed. Majority of the implementing responsibility has been given to the Gram Panchayats and Zilla Panchayats primarily function like a facilitator.

Health is one of the subjects, which has been transferred to PRIs in Karnataka. Karnataka has also transferred funds, functions and functionaries to PRIs. Without competent officials under the control and supervision of PRIs, even if the PRIs have funds, it would be difficult for them to execute development programmes effectively. Functionaries are pivotal to the PRIs. In Karnataka, the functionaries, besides implementing the activities assigned to the PRIs, also implement state and national programmes under the director supervision and control of the Health and Family Welfare department. Under these circumstances, it is necessary to understand, whether, the PRIs elected representatives, are able to effectively supervise the functionaries.

Planning Commission assigned this study to IDPMS to analyse

- The Roles and Responsibilities of health functionaries
- Whether the PRIs are able to effectively monitor the functioning of health officials
- And whether this has had impact on the outcomes.

The study was conducted across eight districts randomly selected; from these districts 16 taluks were randomly selected. From the selected taluks 80 GPs and 80 PHCs were selected. Besides around 720 outpatients visiting the PHCs were interviewed.

### **Key issues:**

The study threw up key interesting issues.

- Whether the elected representatives, are aware of the provisions available in the Act, which give them scope for supervision and monitoring of health functionaries.
- What are the perceptions of the elected representatives and functionaries?
- Was there failure of institutions?

- Whether the elected representatives are capable enough to review the performance of functionaries
- Whether social audit process and feedback mechanism is set in motion.

### **Conclusions:**

The study has discussed these issues at great length and following major conclusions are drawn.

- Elected representatives are not aware of certain provisions available to monitor the performance of functionaries and they have not used these provisions effectively.
- Standing Committee members have neither obtained reports from the TP & GP regarding the performance of health functionaries, nor specific studies or surveys conducted to review and evaluate the health outcomes. Monitoring visits were not made to the health centers and villages.
- Standing Committee meetings are not effective. Annual goals and budgets are not fixed and reviewed regularly. Key issues like absenteeism of doctors and drug stock outs, outreach works are not part of review process.
- ZP, TP, GP presidents are not capable enough to review the performance of health functionaries.
- There is lack of coordination between PRIs and health functionaries.
- GP Presidents and VHSCs have broadly understood issues discussed in VHSCs.
- Villagers are aware of various government schemes. Awareness and IEC camps are done regularly.
- VHSCs are not considered as sub-committee of GP and are not privy to health information.
- Health information registers are not maintained at VHSCs and public dialogue meetings are not held
- RKS & ARS do not prepare plans for spending untied funds. They do not function like independent NGOs. They have not mobilized local resources.
- ANMS & ASHAS do not submit fortnightly reports to VHSCs. GP Presidents do not supervise SCs and Anganwadis.
- Jansunvais are not held, defeating community monitoring goal under NRHM.
- Drug stock out and out pocket expenses are a serious concern
- Patients do not normally complain about grievances; they do not have confidence in elected representatives.



## Recommendations:

- Sensitization and capacity building training programmes should be conducted for elected representatives and health officials, in order to bring proper coordination and remove the trust deficit.
- Training programmes should be conducted for elected representatives to make them aware of their roles and responsibilities and available provisions under the Act for them to monitor the work of health officials.
- It is suggested to build a management information system across the three tiers preferably independent of health department that could improve the quality of discussions in Standing Committee. As part of monitoring process, frequent studies and surveys should be conducted.
- Standing Committee members at all the three tiers could visit health centers and villages regularly and interact with community.
- Exhaustive training programmes should be conducted for elected representatives before any powers are given to review the performance of health functionaries. Cautious steps have to be taken in this regard.
- Wider consultations could be held with health fraternity, legal and PRI experts before drafting a detailed performance review system. An expert committee should be constituted.
- It is suggested that to start with elected representatives may be given the responsibility of performance review of health functionaries working under their geographical jurisdiction. But they should do so after consultations with DHO and CEO.
- However ultimate authority should be with DHO and Health Commissioner. They should mandatorily consider the reviews of elected representatives.
- Enough opportunities should be given for the health officials to contest these reviews.
- To start with on a pilot basis, in selected GPs, salaries of ANMs and SC staff could be deposited with GPs and salaries of MOs and PHC staff could be deposited with TPs. GPs and TPs in consultation with the community may release the salaries after their performance is reviewed. They may be provided with proper escort services.
- Proper capacity building programmes have to be conducted for ARS/RKS/VHSC members in respect of conducting meeting, budgeting, accounting and management.
- Jansunvais should be mandatorily conducted by GPs with the help of independent well meaning publicly acclaimed persons. The outcome of this social audit could be the basis to review the performance of health officials and the quality of health services.

## **SECTION – I**

**The Design and the Structure of the Report are laid out as follows**

## **SECTION II –BACKGROUND**

The section explains a gist of the 73<sup>rd</sup> and 74<sup>th</sup> Amendment of the Constitution and the structure of the decentralization of powers to the Gram Panchayats in Karnataka. The relevance of the study, objectives and the hypothesis on the study conducted are discussed here.

## **SECTION III – FUNCTIONS OF PRIs IN KARNATAKA**

This section details the Activity mapping of the functionaries and their roles in the decentralization process

## **SECTION IV- DATA ANALYSIS AND FINDINGS OF THE FIELD SURVEY**

Issue wise topics have been discussed bringing together the responses of PRIs and health functionaries of all the three levels

## **SECTION V – NATIONAL RURAL HEALTH MISSION**

The coordination and linkages between institutions of governance and health functionaries at the ground level have been discussed in this section in length.

## **SECTION –VI – OUTPATIENT**

Details of the responses of the PHC out patients and the quality of the service provided comes out in this section

## **SECTION VII – SUMMARY AND CONCLUSIONS**

The comprehensive and concise summary and conclusions are form the part of this section.

## **SECTION VIII – RECOMMENDATIONS**

List of recommendations are provided in this section. Recommendations have linkages with the field findings. Many of them have also policy implications

## **SECTION –II**

### **BACKGROUND**

With the 73<sup>rd</sup> and 74<sup>th</sup> amendments to the Indian Constitution in 1993, the process of decentralization was set into motion. Many commentators thought that this was a panacea for all the ills of local administration. Basically with these amendments, it was envisaged to deepen the democratic foundations of the Indian nation.<sup>1</sup> The 73<sup>rd</sup> amendment recognized PRIs as Institutions of self- Government. However there were mixed reactions both from the legislatures and bureaucracy. Both of them apprehended that PRIs may deprive them from hitherto enjoyed power. Most of the states have complied with two requirements namely, setting up of State Election Commission and State Finance Commission. However with regard to transfer of power and responsibilities and the three F's -funds, functions and functionaries- the states have taken very lukewarm steps. The three F's are essential ingredients for smooth functioning of PRIs. The last one that is functionaries is very important since it is the human resource which transfers the ideas into action. Karnataka (where the current study is conducted) it is observed, has transferred all the 29 subjects listed in the 11th schedule of the Constitution. However, studies have shown that this is only partial (Vaddiraju and Sangita 2011, Rajashekar and Sathpathy 2007). The former study has also found out that one of the most difficult and inadequate part of devolution in Karnataka was devolution of functionaries. The Rajiv Gandhi Foundation conducted a series of workshops in all the four regions of the country and it is no surprise that all the regional workshops have concluded that the states were not forthcoming in transfer of powers, functions and functionaries and have come out with strong recommendations especially with regard to functionaries.<sup>2</sup> They have recommended to have a separate and autonomous cadre of Panchayat bureaucracy. It has recommended for transfer of adequate staff and they should be placed under control of PRIs. Another important recommendation was that there should be no dual control of staff deputed to PRIs. Duplication of services should be stopped. Mr S.S. Meenakshisundaram, a senior civil servant has commented that "Bureaucracy is known for its resistance to change. It tends to oppose changes that cause a net reduction in the amount of resource that is under its control. The bureaucracy in general would prefer the status quo to be frozen to perpetuity."<sup>3</sup>

Primary health care is one of the subjects that have to be transferred to the PRIs. Karnataka has transferred health subject to PRIs. It is generally believed that decentralization of health services would result in greater community participation.

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<sup>1</sup>Vyasulu Vinod Decentralisation, Democratisation, and local finances after 73<sup>rd</sup> Constitutional amendments, March 2001

<sup>2</sup> Task force on panchayat raj, Rajiv Gandhi Foundation 1999

<sup>3</sup>Meenakshisundaram S.S. " Interface between officials and elected representatives in Panchayats" in Renewing Local Self-Government in Rural India, Occasional papers Government of India Ministry of Rural Development New Delhi 1995

Both the National Health Policy (2002) and National Population Policy of Government of India (2000) emphasized and recognized the role of PRIs in primary health care. Even the National Rural Health Mission (NRHM) recognizes the critical role to be played by the PRIs in planning, implementation and monitoring of the NRHM.

PRIs have a central role to play in improving the health status of the rural poor. The functionaries play a pivotal role in providing quality health care to the rural poor and disadvantaged and this can succeed if the functionaries are accountable to the PRIs.

### **1.1 Relevance and Need for the Study**

Enough literature is available and research studies have been made on constitutional and legal issues related to the local government. Research studies have also been made on PRI budgets. Finance Commissions constituted as per the Constitutional mandate have dealt exclusively about the panchayats and urban local body's budgets and allocations to these local governments. Most of the national programmes related to rural employment and public health like NREGA and NRHM have been using the PRIs for implementation of the programmes. The ministry of Rural Development, Government of India has recently raised its discomfort on sidelining of PRIs. The progress of these schemes depends much on the role and authority of the PRIs. Not enough research has been done with regard to the functionaries who are vital for translating the ideas and policies of the government into actions.

The proposed study will throw light on the ground realities that are prevailing with regard to role and responsibilities of the functionaries who are deputed from the state. The study could also be useful to revisit budgeting and allocation process. With this background, it was planned to make a detailed study with the following objectives-

### **1.2 Objectives**

1. To analyze the roles and responsibilities of health functionaries working under the PRI system.
2. To analyze the scope and effectiveness of PRIs in over sighting, monitoring and regulating the public health staff.
3. To understand and analyze the impact on the quality of health services in the prevailing situation.

### 1.3 Hypotheses to be tested

1. PRIs have sufficient role in delivery of health care services.
2. New approaches under PRIs have sufficient scope for effective functioning of health bureaucracy

The study is empirical and primary data are collected on a sample basis from randomly selected eight districts of Karnataka through administration of appropriate survey instrument. Data from secondary sources also are collected from the PRIs and from the department of health and family welfare, Government of Karnataka

### 1.4 Statistical Design

There are four revenue regions in Karnataka. Two districts each are randomly selected from each revenue regions, adding to total of 8 districts. Later, from each of the district, one taluk is further randomly selected for the purpose of studying the role of PRIs at middle tier- i.e. at taluk panchayat.

The selected districts from each of the revenue regions and taluk selected from each of the selected district are as follows-

#### Revenue Division & Districts Selected for the Study

Table: 2.1

Sl. No	Revenue Division	Districts selected	Taluk selected
I	BANGALORE	1.Bangalore	Hosakote
		2.Chitradurga	Challakere
II	MYSORE	1.C.R. Nagar	Kollegal
		2.Hassan	Arsikere
III	BELGAUM	1.Gadag	Gadag
		2.Bagalakot	Badami
IV	GULBERGA	1.Koppal	Koppal
		2.Bellary	Bellary

From each of the selected Taluk, 10 PHCs are further randomly selected as follows:

#### PHCs selected from Taluks for the Study

**Table: 2.2**

Sl. No	Taluk	PHC	Sl. No	Taluk	PHC
1	HOSAKOTE	Mugabala	3	KOLLEGAL	Bandahalli
		Nandagudi			Sathengala
		Sulibele			Palya
		Bendiganahalli			Maduvanahalli
		Anagondanahalli			Kamagere
		Muthsandra			P G Palya
		Jadigenahalli			Koudahalli
		KhajiHosahalli			Chilakawadi
		Bailanarasapura			Hanur
		K Mallasandra			Lokkanahalli
2	CHLLAKERE	Ramajoghally	4	ARSIKERE	Handralu
		Meerasabihalli			Karagunda
		Parashuramapura			Hiresadarahalli
		Bedareddihalli			Kenkere
		DoddaUllarthi			Kamasamudra
		Nelagetanahatty			Undiganala
		DoddaChellur			Harannahalli
		Jajuru			Javagal
		S Durga			Banavara
		Thaluku			Bhageshpura
5	GADAG	Negavi	7	KOPPAL	Kavalur
		Harti			Avalandi
		Mulugund			Betageri
		Kanavi			Bhagyanagar
		Betageri			Kinnal
		Kurtkoti			Irakalagada
		Hulkoti			Kukanapalli
		Lakkundi			Indaragi
		Chichali			Hittanal
		Hombal			Ginigera
6.	BADAMI	Belur	8	BELLARY	Roopanagudi
		Thogunshi			Cellagurki
		Nandikeshwar			S Mola
		Katageri			M Gonal
		Halakuruti			Moka
		Kakanur			Sanganakal
		Kerur			Korlagundi
		Mushtageri			Koluru
		Kulageri			Siddammanahalli
					Kuditini

Data are collected at all the 3 levels- District, Taluk and Gram Panchayat. The data collection is done with different health officials, elected representatives, relevant executives who are involved in health. Besides, information is collected from various subcommittee members and users/beneficiaries at different levels. The data collection is made mainly through structured questionnaires. Contents of the questionnaire mainly are pertaining to information regarding the existing roles, responsibility, political interference, awareness of their functions and responsibilities, their perceptions about strengthening the power of PRIs. Questionnaires used for data collection are placed under the section – Annexures appended at the end of this report.

The details of the interviews done at different levels are as follows-

- District level- 8 DHOs , 8 ZillaPanchayat Presidents, 8 CEOs, 8 officials of planning department, 8 chief account officers, 8 standing committee members, 8 RCH staff, 16 (2 members/NRHM society) NRHM society members, 16 officials (2 members/district) from centrally sponsored schemes are selected.
- Taluk level- 16 CHCs, 16 Rogikalyansamiti members, 8 THOs, 8 TMOs, 8 EOs, 8 TP Presidents, 8 taluk health subcommittee members are selected
- GP level- 80 PHC doctors, 80 GP presidents, 80 ArogyaRaskhaSamitis, 650 PHC users and 160 sub centre staff are selected

## **SECTION- III**

### **ROLES & FUNCTIONS OF PRIs IN KARNATAKA**

The Karnataka Zilla Parishads, Taluk Panchayat Samitis, Mandal Panchayats and Nyaya Panchayats Act of 1983 which came into effect in 1987 transferred as many as 257 plan schemes to ZPs and 86 plan schemes to Mandal Panchayats falling under 20 line departments. Public Health was one of the subjects that were transferred to PRIs. Mandal Panchayats besides implementing their own schemes also implemented schemes of ZPs. Nine Standing Committees were formed and Health Committee was entrusted to look after Health Services, family welfare, hospitals, drinking water and related allied matters. This Act had certain provision for close interaction between health functionaries and PRIs at both the levels.

In conformity with the Eleventh Schedule of 73<sup>rd</sup> Constitution amendment, Karnataka enacted The Karnataka Panchayat Raj Act of 1993. This Act has assigned duties and functions to the three tiers of Panchayat Raj system under three different schedules. Schedule I was for GP, Schedule II was for TP and Schedule III was for ZP. Under this Act, GP can discuss and take appropriate action of public health related issues. There is also a provision under the Act to form Amenities Committee (Standing Committee). However, the challenge is to make the legislative transfer more meaningful, by ensuring that distortions that have crept in through departmental scheme guidelines are removed. A significant step in this direction has been taken through formally issuing a detailed activity mapping for each PRI. The new activity mapping framework has a significant impact on how line departments function. Delegation of functions is accompanied to a certain extent by devolution of finances and functionaries also. ZP and TPs will perform more of a facilitator and planner and GP will perform the role of an implementer and service provider and Gram and Ward Sabhas will be instruments of downward accountability. (Activity Mapping of PRIs in Karnataka ANSSIRD 2012) The Activity Mapping has to a considerable extent reduced the overlapping of schemes across the three tiers.



### ACTIVITY MAPPING OF PRIs IN KARNATAKA

TABLE NO: 3.1

	FUNCTIONS UNDER HEALTH CARE		
	<i>Zilla Panchayat</i>	<i>Taluk Panchayat</i>	<i>Gram Panchayat</i>
1	Plan through health committee to provide physical infrastructure	Assist in supervision and maintenance of sub centres and deployment of field staff	Assist in formation of village health committees comprising Panchayat members, representatives of villagers, village health guide(VHG), Trained Birth Assistant(TBA) and multipurpose health workers
2	Coordinate communicable diseases programme with the state	Supervise mid day meals schemes for school children	Upkeep of village sanitation, cleaning of roads and drainage
3	Coordinate construction and maintenance and supervision of PHCs	Organise health and family welfare camps and conduct demonstration-cum- exhibition programmes on health, family welfare and sanitation	Mobilize and organize people for health and family planning and immunization camps
4	Maintain district ISM (Indian System of Medicine) hospitals	Assist in supervision of ISM (Indian System of Medicine) dispensaries.	Coordinate and supervise construction of sanitary latrines
5	Periodically conduct Epidemiological surveys		
6	Promote school health programme		
7	Organise health awareness rallies and camps		

<b>FUNCTIONS UNDER SANITATION</b>			
	<b>Zilla Panchayat</b>	<b>Taluk Panchayat</b>	<b>Gram Panchayat</b>
1	Plan for rural sanitation programme	Organise and supervise sanitary marts	Chlorinate village tanks and wells and spraying of DDT
2	Promote Information, Education and Communication (IEC) campaigns	Formulate plan for assisting in the construction of sanitary latrines	Assist in construction of individual sanitary latrines
3		Assist in inspection/assessment of quality of public health inputs and services	Report of outbreak of epidemics
4			Assist in coordinating emergency medical relief services

(Notification No: RDP.367.ZPS.2002 dt. 18-08-2003)

## **ROLES OF THE THREE TIERS UNDER THE PRIs**

### Zilla Parishad (ZP)

- ZP has the role of planning and coordinating the health activities in the districts.
- All facilities 100 beds and below are under the supervision of ZPs. Hospitals and facilities above 100 beds are under the State sector.
- ZPs have planning and implementation role and responsibility in respect of construction of PHCs; CHCs sub centres, maintenance of hospitals, supply of drugs, and overall promotion of various schemes.
- Both funds and functionaries are under ZP. In respect of family welfare programmes, ZPs can plan and implement and functionaries coordinate the activities.

### Taluk Panchayat (TP)

- TP has specific roles in respect of establishment of sub centres and PHC.
- They can plan and implement, supervise, promote schemes.
- They handle funds and functionaries.

- They coordinate and supervise mid day meal schemes and health camps for school children.
- In respect of family welfare schemes, TPs have a role in promotion.

#### Gram Panchayat (GP)

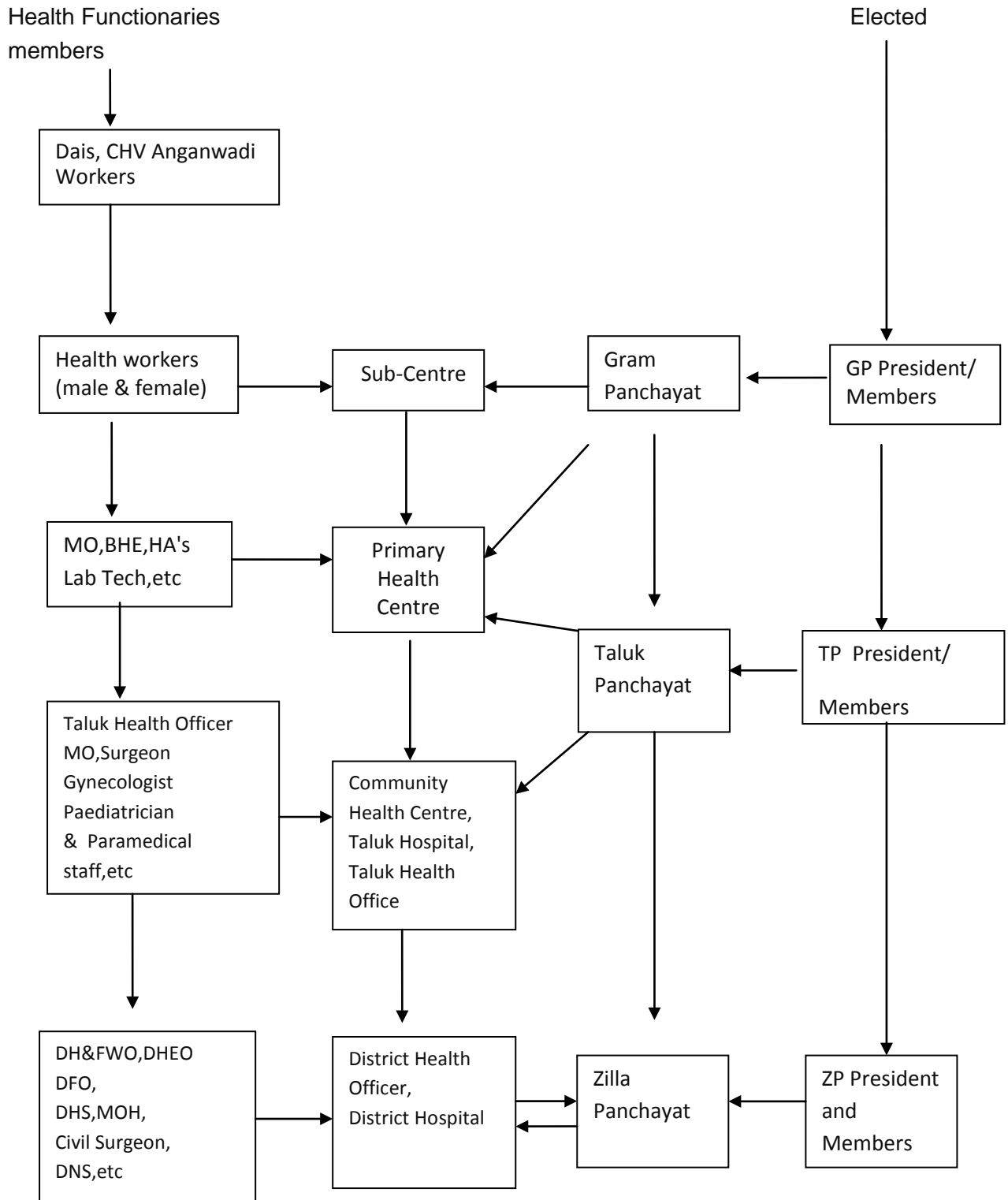
- GPs have more of a facilitator and promoter role.
- If we analyze the Activity mapping in detail, it is clear that GPs do not have any direct role or responsibility in health related issues except undertaking promotional activities.
- Under sanitation, GPs have greater responsibility. They do not have specific role in planning implementation, supervision, handling of funds and functionaries as far as health and family welfare activities are concerned.

Thus the activity mapping has brought a great extent of clarity among the three tiers about the health, family welfare and sanitation activities.

How do the linkages between PRIs and health functionaries exist in Karnataka? The following chart (Sekar 2002) explains the linkages.

Flow Chart 1

**Linkages between PRIs and Health Care System at the District level in Karnataka**



The above chart shows that, GPs are in direct link with Sub Centres and PHCs, which are under its jurisdiction. The ANMs and other field officers attached to SCs and PHCs visit villages regularly and also individual houses for identifying persons afflicted with TB, collect sputum samples and also administer DOT tablets. Likewise, they collect details regarding maternal and child health care. They also collect details about vector borne diseases. In addition to these responsibilities, they do conduct mothers' day, children and nutrition day programmes.

There are certain places where, PHCs are situated at GP head quarters. The health functionaries should involve GP members in conducting these promotion camps and also share the information collected on the aforesaid diseases. This also amounts to setting goals with regard to village visits, data collected, promotional work done, number of camps conducted etc. This helps not only in monitoring the work of the field level functionaries but also educating GP members regarding health related issues. Whether such type of coordination and linkage is happening at the ground level or not is discussed further in the succeeding chapters.

At the ground level, GP has to be in touch with the health functionaries of sub centres and PHCs working under its jurisdiction. Similarly TP may have relationship and coordination with PHCs and CHC working under its jurisdiction. Similarly ZP takes care of hospitals and establishments working under its jurisdictions and implements various schemes along with DHO. However though the chart explains the linkages, it is not clear in reality how do the linkages operate?

The activity mapping gives a clear picture of various functions coming under PRIs. With regard to roles and responsibilities of health functionaries, during our field visits majority of them informed that there are no specific roles and responsibilities to be performed under PRIs. They are discharging their roles and responsibilities as per the directions of Health Commissioner. They take the support and help of the elected representatives during conduction of health camps, pulse polio camps etc. As the linkage chart exhibits, public health is visible at the GP level. Starting from MO and upwards, it is hospital management and treatment of diseases and patient. These issues are further elaborated in the coming chapters.

## SECTION -IV

### OBSERVATIONS OF THE SURVEY, FINDINGS AND RECOMMENDATIONS

In this section, views and opinions expressed by the elected representatives and the officials of the health department at the three levels namely, ZP, TP and GP are recorded by administering them questionnaires, tabulated and analysed. Depending on the nature of questions and views expressed, they are regrouped in the following order-

#### 4. 1 Zilla Panchayat /Taluk Panchayat President(s)

Zilla Panchayat (ZP) /Taluk Panchayat (TP) is a body constituted under the Karnataka Panchayat Raj Act, 1993 (KAPRA 1993). The Zilla Panchayat/Taluk Panchayat is a body corporate and is assigned a legal status. The Zilla/Taluk Panchayat is entrusted with execution of development schemes, providing civic functions in rural areas and looking after the duties of the government delegated in respect of certain department as per the schedule. All the 29 subjects transferred to PRIs in Karnataka including Family welfare and health.

As per the Act, the ZP has the responsibility of plan formulation and implementation for district development at district level. The planning process, in the above scenario, can be categorized as follows: state planning at the state level, ZP planning at the district level and gram panchayats planning at the below-district level. In the above context, in our study, both elected representatives and officials were asked the role of elected representatives in the health planning process.

#### Health budget Planning & Monitoring process:

Table: 4.1.1

Role of ZP/TP in Health Planning		
Description	ZP President(N=8)	TP President(N=8)
DHO/CAO/CPO prepares & places before the HESC	2(25%)	0
There is a limited role,	3(37.5%)	7(87.5%)
Give suggestions	3(37.5%)	1(12.5%)

<b>Role of ZP/TP in Health Monitoring</b>		
Active role and actions initiated	1	0
Limited role and Most of the functions are with the officials, give suggestions	5(62.5%)	6(62.5%)
Visit hospitals frequently & give inform officials based on complaints & issues	0	1
Lack of coordination with officials/ Cannot initiate actions on officials	5(62.5%)	1

### **Roles Performed by General Body and Standing Committee**

**Table: 4.1.2**

<b>Description</b>	<b>ZP President</b>		<b>TP President</b>	
	<b>General Body</b>	<b>Standing Committee</b>	<b>General Body</b>	<b>Standing Committee</b>
Final decision and approval of action plan	3(37.5%)	0	5(62.5%)	0
Only Advisory. Giving suggestions	1(12.5%)	4(50%)		5(62.5%)
Poor coordination with health officials		1		

*Note: Multiple answers are given.*

In case of ZP presidents, 25% of them are aware of the process of planning and 37.5% of them said they give suggestions. 87.5% of Taluk Panchayat Presidents said they are not aware of the roles or having very limited role.

Our observations are that the elected representatives feel, their roles are very limited and most of the time it is only to give suggestions. Some of them are also not aware of their roles. They expressed they do not get proper information and data from the health officials. Hence giving suggestions is also difficult.

## Process of Health Planning done at different levels

**Table 4.1.3**

Description	THO	MO-CHC	DHO
As per the guidelines for NRHM	1	3	0
Regular schemes-need and evidence based	1	9	1
Based on inputs from SCs, draft plan is prepared	0	1	0
Based on previous years allocations	0	4	0
Based on priority list prepared and pertaining to various programmes	0	2	0
Under guidance of DHO/National programmes	0	2	0
Based on input from CHC/PHC/Taluk plan	2	0	4
Only for Taluk level/peripheral hospitals	1	0	0
District surveillance unit	0	0	2

## Health Planning at the level of ZP officials

**Table: 4.1.4**

Description	CEO	CPO	DHO	EO
Requisition made by ZP; budgets made by TP/GP and consolidated	7 (87.5%)	1 (12.5%)	4 (50%)	0
It is a routine process; consultations held with health officials at all levels.	1	2	1	0
Through DHO office; CPO involved	2	1	0	0
THOs prepare plan based on inputs from MOs of PHCs. and consolidated	0	5 (62.5%)	3 (37.5%)	7 (87.5%)



ZP presidents are aware that the actual process of planning and budgeting is carried out by CPO, CAO and DHO. Also they felt, they can give suggestions. Presidents of ZP and TP seemed to consider Planning and Monitoring as a Technical process. Besides GP does it's planning by conducting GS, MOs with the help of ANMs and now after NRHM with the help of ANMs and ASHA workers, prepares the plan and submits to TP. As evident from the answers, all the health and ZP officials more or less have agreed that ZP consolidates plans prepared by DHO which in turn is done by aggregating the THO & MO plans. Role of ZP is to review the plan prepared by DHO as to whether the plan is prepared as per the guidelines. ZP & TP presidents lack full awareness of their role and responsibility. Moreover, generally there is a tendency to leave the detailed scrutiny and discuss to the General Body which ultimately approves the plan and budget.

The situation is not different in monitoring of health activities. ZP presidents have hardly visited the health centres. They have felt, they have limited role, all the powers are vested with the officials and there is lack of coordination. Since ZP president is also the President of the H&ESC, he could have seized this opportunity to visit the health units along with other members, get reports from TP & GP on functioning of health centres and functionaries, attend to complaints from citizens and act on them. ZP & TP presidents have not understood inherent powers vested with them as head of governance institutions. Clearly there is lack of coordination.

#### Conclusions:

- *There should be continuous training programmes for the ZP and TP Presidents and members about their role and responsibility in planning budgeting and monitoring.*
- *Similarly DHO THO and MO should also undergo training, focusing more on recognition of the role of ZP institutions, and importance of coordination.*
- *There is lack of sharing of information which is very essential for ZP, TP & GP presidents and members to take informed decisions. Information is power and empowerment happens when they have access to information.*
- *PRIs should explore the possibility of establishing a joint community monitoring process of the health facilities and functionaries*
- *Various processes adopted by the health officials at all the levels lack insight and are very routine. Had there been proper coordination and discussion with the respective PRI set up health plan and budget could be qualitatively better.*

## Sharing of information with PRIs by Officials

Respondents: Officials

**Table: 4.1.5**

Description	Yes	NO	TOTAL
DHO(8)	8(100%)	0	<b>8</b>
THO	6(75%)	2(25%)	<b>8</b>
MO-CHC( 16)	2(12.5%)	14(87.5%)	<b>16</b>

### Type of Information Shared with PRIs

- THO**
- Outbreak of diseases' shortage of drugs, maintenance of hospitals.
  - Any info asked by PRIs
  - KDP meeting, immunization, nutrition day etc

- DHO**
- Any info asked by PRIs
  - Outbreak of diseases etc
  - Standing committee approval
  - Draft action plan shared
  - Doctors' attendance, epidemics, maintenance of hospitals etc

Most of the DHOs (100%) and THOs (75%) said that they share information with PRIs. They share information mostly related to outbreak of diseases, immunization, nutrition day, maintenance of hospitals etc. DHO and THO gather information from the officers down below.

One of the critical issues that came up for discussion during our visit was absence of sharing of information by health officials with the PRIs. Responses to our questionnaire are on the same lines. Not sharing of information by MOs with GPs amounts to disobeying PRIs. There is a perception issue. Health functionaries exhibit a superiority complex and tend to be casual when dealing with GPs as PRIs do not have power and authority to take action against officials. This perception has to be changed. On the other hand access to proper information by GPs empowers them and enables them to take proper decision.

MOs have not shared information. For elected members of GPs access to information is very important. They are vested with the responsibility of implementation of various programmes at the ground level. During our interactions with a few GP presidents, we understood that their participation in nutrition day, mothers' day etc is only ornamental and no purpose is served. Lack of information handicaps them to plan, provide suggestions and take appropriate decisions. If this situation has to change, they have to get regular information from the MOs, ANMs and ASHA workers.

Conclusions:

- *The information shared could be quantitative in nature. If Presidents of ZP and TP could collect information from the TPs and GPs, it would give them an opportunity to cross check and verify data provided by both the information channels. Information related to absenteeism of doctors and para medical staff, availability of medicines, functioning of equipments, availability of water & power, could be useful to the presidents and members of PRIs to take proper decisions and monitor the functionaries.*
- *H&FW department in consultation with the RDPR department should give directions to the health officials to compulsorily share information with PRIs; health officials should mandatorily associate with PRIs in preparing health plan and budget.*
- *PRIs should keep proper documentation about proceedings, plans, budgets, surveys, monitoring reports etc. They should be made available to the general public.*

#### Views of ZP/TP President on providing statutory powers to the PRIs

Table: 4.1.6

Description	ZP President	TP President
Give more powers to PRI	6(75%)	8(100%)
Continue with the existing system	1(12.5%)	0
No answer	1(12.5%)	0
No power should be given	0	0
Delink health activity from PRI	0	0
<b>TOTAL</b>	<b>8</b>	<b>8</b>

Most of the ZP/TP Adhyakshas were unanimous in demanding more powers to the PRIs. All the TP presidents (100%) and 75% of the ZP Presidents said that they should be given more powers.

### Views of Officials on Providing Statutory Powers to PRI:

**Table: 4.1.7**

Description	DHO	CHO	MO- CHC
No power should be given to PRI	4(50%)	3(37.5%)	3(18.75%)
Delink Health activity from PRI	3(37.5%)	4(50%)	6(37.5%)
Giving more powers to PRI	0	0	1(6.25%)
Continue with existing system	1(12.5%)	1(12.5%)	5(31.25%)
Other suggestion	0	0	0

Most of the officials, expressed that statutory powers should not be given to PRIs. Some of them (37.5% to 50%) feel that health activity should be delinked from PRIs. During the personal discussion, they expressed that PRIs unnecessarily interfere and because of them, progress gets hampered. Also according to many MOs with whom we spoke expressed that due to political interference, they are not able to work peacefully. They prefer everything to be controlled by the Family welfare and Health Department only.

### Views of ZP/TP President on Effectiveness of Health System if PRIs are completely involved

**Table: 4.1.8**

Description	ZP President	TP President
Very effective /Effective /Better coordination	6(75%)	7(87.5%)
Less effective/ Not effective	1	1
Cannot say	1	0
<b>TOTAL</b>	<b>8</b>	<b>8</b>

Majority of the ZP Presidents (75%) and TP Presidents (87.5%) felt functioning of the health system in the districts would be very effective if more powers are given to the PRIs. Also they felt there should be better coordination between PRIs and officials so that functions would be very effective.

## Views of Officials on Effectiveness of Health System if PRIs are completely involved

**Table: 4.1.9**

Description	DHO	CHO	MO- CHC
Very Effective	0	0	0
Effective	2(25%)	1(12.5%)	1(6.25%)
Less Effective	1(12.5%)	1(12.5%)	8(50%)
Not Effective	4(50%)	4(50%)	5(31.25%)
Cannot Say	0	0	2(12.5%)

From the above table, we can see that more than 75% of the officials feel that functions of the health system will be either less effective or not effective at all if PRIs are completely involved.

Answers from both the health officials and ZP & TP presidents are on the expected lines. These answers could have come due to ego and apprehensions of health officials of losing power/PRIs getting power. Even 20 years after KPRA came into operation, health officials would not like to work under the PRI set up. The officers feel PRI structure is a hindrance for them to take decisions in whatever manner they want. They would rather be happy to work under the direct supervision of Health Commissioner. Though the officials complained about political interference, this was not well substantiated. Health officials feel threatened due to nearness of the review and monitoring authority. But this is the essence of decentralised governance. Decentralised governing institutions have still not got the confidence of the bureaucracy working under them. There is need to remove this mistrust. Due to these reasons there is also lack of coordination at all the levels.

As it is in the Activity Mapping Construction, maintenance and supervision of health centres is the responsibility of ZP. ZP President and members have not used this option effectively. In West Bengal, in 2007, it was decided to keep the Salary of ANM and Anganwadi workers with the GPs and they in turn pay the salaries after reviewing the performance. Cardinal principle is money should follow the patient and not the doctor. If this is adhered to, improvement in the performance of the functionaries can be seen.

### **Case Study No: 1**

#### ***Gram panchayats and health staff- clash of egos.***

Her voice was stern and shrill. With a straight face she said, “ I would like to be monitored by the Medical Officer of PHC rather than by the President of GP.” Rukmini ( name changed) middle aged ANM who has put in more than ten years of service at Bandigere PHC of Chamarajanagar a backward district in the southern part of Karnatka, substantiated her statement with an incident that happened about a decade ago. When the government of Karnataka was contemplating to make GPs the monitoring and reviewing authority for ANMs and Anganwadi workers, their union did a state wide agitation and brought the government on its knee. Government dropped the plan. Has the situation changed now? “Not really” averred Rukmini. Contempt was writ large on her face. Clash of egos keeps GPs and health staff apart.

#### **Conclusions:**

- ZP & TP Presidents have not utilised the available options in the KPRA and in the Activity Mapping.
- Mistrust and ego issues are playing a major role.
- Health officials are not welcome to the idea of monitoring their performance from ZP; they would prefer from an authority located away from their work. They would like to work directly under Health and Family Welfare department.

#### **Recommendations :**

- *As a good practice of democracy ZP should be vested with monitoring and reviewing role*
- *On a pilot basis, in selected GPs salaries of ANMs and SC staff should be deposited with GP and based on their performance and with the consent of the local community salary can be paid.*
- *Similarly Salary of MO and other paramedical and non medical staff of PHC could be deposited with the TP. After reviewing their performance, salary can be disbursed.*

- ZP should set up a system to get reports from TPs and GPs on the functioning of health centres, implementation of programme and also performance of the health officials.
- While implementing such pilot programmes, help of local NGO could be taken for hand holding<sup>4</sup>
- Under the Activity Mapping, GP President has role to visit Aganawadi centres and SCs and review their performance. If they regularly visit these centres, there could be improvement in the functioning of the centres and also Anganwadi workers and ANMs.

## HR ISSUES

### Information by ZP/TP on sanctioning leave/write CRs/take disciplinary action of district health staff

Table: 4.1.10

Description	ZP President	TP President
ZP President	0	0
DHO	4(50%)	6(75%)
Health Commissioner	2(25%)	0
Others (MO)	1(12.5%)	0
Don't know	3	2
Total	10*	8

\*Multiple answers are given

All powers and authorities regarding sanctioning leave, taking disciplinary actions writing confidential reports are vested with the DHOs who represent the State in the district. The PRIs do not have any role in this. The Health staff are functionaries of the State government and are deputed to the PRIs. The responses by ZP Presidents and TP presidents also corroborate this. Most of the ZP Presidents (87.5%) and 75% of the TP Presidents said that sanctioning leave or taking disciplinary actions can be done by DHO or Health Commissioner. None of them said PRI officials like CEO has also a role in writing CRs or taking disciplinary actions.

<sup>4</sup> Enhancing Administrative Capabilities of Grama panchayat in Kolar district ([www.arhyam.org](http://www.arhyam.org))

### Information by Officials on Reviewing Authority of Taluk Level/District Level Staff

To know the perspective from the officials, questions were asked regarding the reviewing and monitoring their performance. Only 37.5% of DHOs and 12.5% of CHOs said that CEOs are also involved in reviewing. Rest of them are unanimous in their response that DHO will review their performance.

Respondents: Health Officials

**Table: 4.1.11**

Description	DHO(8)	CHO(8)	MO CHC(16)
DHO	4(50%)	6(75%)	0
DHO/CEO	3(37.5%)	1(12.5%)	0
DHO/THO	0	0	8(50%)
THO	0	0	7(43.75%)
<b>TOTAL</b>	<b>7</b>	<b>7</b>	<b>15</b>

The reviewing authority vests with the officials. Of course normally the superior officers review the performance of officers who report to them. The review reports are sent to the health commissioner for further review and recommendation. The superior officers write the confidential reports of their subordinate officers. This job is done in majority of cases by DHO. DHO is also authorised to initiate disciplinary action. Then he will report and recommend to the health commissioner who is the overseeing officer. All the health staff, as a matter of fact all the PRI staff are employees of the state government. They are governed by the cadre and recruitment rules framed and enacted by the State. PRIs do not have a separate cadre and recruitment power and no rules are framed. Hence PRIs cannot review the performance of Health officials and write their CRs. In the 1987 KPR Act, ZP Adhyaksha was vested with the power to write the CR of CEO who was an Indian Administrative Officer senior in grade over the district collector. Likewise the down below PRI heads had the power to write the CRs of respective officials. This had brought a certain amount of discipline and workability. In the 1993 KPRA this has been removed. The CEO is not above the grade and seniority of district collector.

Before any drastic measures are taken to provide authority and power with PRI elected representatives, it is necessary to create an enabling condition. Confidence building measures have to be taken. By merely giving the power to write the CRs to ZP/TP/GP presidents, it is not guaranteed that this process will be carried out in a fair and just manner. The capacity and capability of the ZP/TP/GP Presidents has to be built to discharge this



important responsibility. Well defined and accepted measuring yardstick has to be developed. Achievable goalposts have to be agreed upon.

It is also not advisable to give full authority and power with the PRIs to write the CRs and review the progress of health officials. They could be authorised to write their review of health officials, following the measuring yardstick and scrutinising the performance against the goals posts. These reports could be written in consultation with the DHO. If the Health Commissioner is the reviewing officer, it should be made mandatory for him to consider the report of the ZP /TP President before writing the CR. Of course opportunity should be given to the health officials to contest the findings if they are not satisfied. Before this is implemented wider consultations should be held with the medical fraternity and general public. An expert body could be constituted to frame rules and regulations, documentation needed, various steps to be followed for the reviewing process.

### **Conclusions:**

- At present PRI Presidents at the three levels are not competent and capable to review and monitor the performance of health functionaries.
- They do not have powers to review the performance of health officials and write their CRs.
- As per the prevailing rules, DHO and Health Commissioner will write the CRs and review the performance of health officials. Performance of Para medical staff will be reviewed by the corresponding health officers.
- All the health officers and staff deputed to PRIs belong to the Karnataka Administrative Cadre and are governed by the Karnataka Civil Service Rules. They are bound by these rules and regulations.
- Health officials' service records are maintained by DPAR government of Karnataka.
- There exist perception and ego issues.

### **Recommendations:**

- *Exhaustive training and capacity building programmes for PRI Presidents have to be developed and such programmes have to be conducted before any further steps are taken to give powers for PRI Presidents to review the performance of health functionaries.*
- *Before drafting a detailed performance review system, measurement yardstick and achievable goals have to be agreed upon.*
- *Wider consultation with health fraternity, their associations, legal and PRI experts and general public has to be done.*

- *An expert committee to be constituted to draft the reviewing procedure and manual*
- *Ultimate reviewing authority should still be with DHO and Health Commissioner.*
- *However, reviewing authority should mandatorily consider the review report written by the ZP President.*
- *ZP president should consult DHO and CEO while writing the review report.*
- *Enough opportunity should be given for the health officials to contest the report of ZP/TP President.*
- *A separate Karnataka Panchayat Raj Administrative Cadre has to be established.*

### **STANDING COMMITTEES UNDER ZILLA PANCHAYAT**

It is mandatory to constitute various standing committees at three tiers of PRI system. The standing committees can be seen as mechanisms for building co-ordination between different functionaries, representatives and the people.<sup>5</sup> There are five standing committees formed under Zilla Panchayat namely

- (a) General Standing Committee
- (b) Finance, Audit and Planning Committee
- (c) Social justice Committee
- (d) Educational and Health Committee
- (e) Agricultural and Industries Committee.

Each Standing Committee shall consist of members not exceeding seven including the Chairman as specified by the Zilla panchayat elected by the members of ZP. The election of members of standing committee shall be held as soon as may be after every general election of Zilla Panchayat or on its reconstitution or establishment under this act or immediately before the expiry of the term of office of the members of the standing committee.<sup>6</sup>

The Health and Education Sub Committee, apart from being in-charge of all educational activities of the Zilla Panchayat, looks after health services, hospitals, water supply, family welfare and other allied matters in their jurisdiction. The Chairperson of the Standing Committee presides over the meeting. All the Departmental Officers concerned with the subject matters on the agenda must attend the meeting.

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<sup>5</sup> Health Care for the Rural Poor: Decentralization of Health Services in Karnataka, India by T V Shekhar, ISEC, Bangalore

<sup>6</sup> Karnataka Panchayat Raj Act, 1993

For the purposes of this study, one member each from all the selected eight districts from two sub committees namely health & education subcommittee and Finance, Audit and Planning committee were interviewed. The information obtained from their responses is summarized below and suggestions in that regard are spelt out.

To get the views of all the PRI officials about the planning role, questionnaire is administered and tabulated and summarised below-

### HEALTH AND EDUCATION STANDING COMMITTEE UNDER ZP (HESC)

**Table 4.1.12**

<b>No. of meetings held in last one year(N=8)</b>	
Nil	1(12.5%)
6-8 times	2(25%)
Every month(12 times)	5(62.5%)
<b>No. of reviews done in last one year(N=8)</b>	
No review	1(12.5%)
Once a year	6(75%)
3 in a year	1(12.5%)
<b>Issues discussed in last one year(N=8)</b>	
Nil	2(25%)
Epidemic diseases	3(37.5%)
Purchase of equipments	3(37.5%)
<b>Functions performed by committee (N=8)</b>	
Nil	4(50%)
Monitoring	2(25%)
Visits, Purchase of equipments	2(25%)
<b>Role of planning and budgeting(N=8)</b>	
No role	6(75%)
Give suggestions	2(25%)

In Koppal district, there was no proper response. The member whom we met was not able to clearly tell about the number of meetings the committee was having. In most other places, meetings have been held regularly every year.

The Standing Committee has discussed about construction of health centres, purchase of equipment, monitoring and visiting hospitals and other health centres, approval of health plan and budget. As per the activity mapping (Table No: 3.1) Health subject is assigned to ZP. ZP being an aggregator of plans prepared by GPs and TPs, invariably members would have discussed these plans, which are collated by DHO and CPO. DHO has to provide enough information and proper explanations to issues included in the plan and enable the members to have a useful discussion.

When further questioned, members said "No role in planning and budgeting" The Committee does not have power to sanction funds. Members also explained that their visits were to the field for inspection of progress of construction of buildings, functioning of PHCs and health centres. They have conducted surprise visits when complaints are received. They have also done routine visits to health centres at village and taluka levels to monitor, functioning of the health centres. This included regular availability of doctors and other Para medical staff and medicines for the patients, quality of treatment provided, whether equipments are functioning properly, cleanliness availability of water, power, furniture etc. Some of the Standing Committees have discussed shortage of doctors and decided to report to the Government (Chamarajanagar district report). Similarly Gadag standing Committee has discussed about up gradation of SC to PHC.

As per the provisions of KPR Act ZP/Standing Committees can commission surveys and evaluation studies. Health Standing Committee can use this provision and commission studies with regard to performance of functionaries. Even though ZP does not have power to take actions on functionaries, it could recommend certain actions based on the reports. This could act as a deterrent and functionaries may improve their performance.

While reading some of the Standing Committee reports, it was observed that recording of detailed discussions were few. Apart from the recording of decisions taken, discussions could also be recorded.

**Conclusions :**

- Standing Committee discusses issues related to purchases, construction, epidemic diseases,
- Enough information is not provided to the member to improve the quality of discussions.
- Committee does not have power to sanction funds.
- Occasionally members have done surprise visits to health centers.
- The Committee has not conducted evaluation/ monitoring studies.
- Surveys have not been conducted

**Recommendations :**

- *Though meeting regularly and discussing budget issues, the Standing Committee should also discuss issues related to functioning of health centres and performance of functionaries.*
- *Standing Committee can at frequent intervals get reports from the GPs and TPs about the functioning of health centres and bring it before the Committee for discussion.*
- *Standing Committee can commission review and evaluation studies on the functioning of health centres and attendant medical and Para medical staff.*
- *Standing Committee should have surprise visits to the health centres.*
- *Standing Committee should send reports on important issues, outcome of studies and performance of health functionaries.*
- *ZP members should be provided additional training on review and monitoring of functionaries, provisions available under KPR act and Activity Mapping (AV) to bring qualitative change in the functioning of health staff.*

**FINANCE BUDGET AND PLANNING COMMITTEE**

**Table: 4.1.13**

<b>No of meetings held in last one year(N=8)</b>	
No committee	1(12.5 %)
No meeting	1(12.5%)
One meeting	1(12.5%)
4 times meeting	4(50%)
6 times meeting	1(12.5%)
<b>No of reviews done in last one year(N=8)</b>	
Nil	1(12.5%)
One time	6(75%)
<b>Functions performed by committee (N=8)</b>	
Nil	3(37.5%)
Scrutinizing the revenue & receipts and expenditure	4(50%)
<b>Role of planning and budgeting(N=8)</b>	
No role/limited role	4(50%)
Review of proposal related to finance, no role in health planning	3(37.5%)

The ZP President (Adhyaksha) is the Chairman of the Finance, Audit and Planning Committee. One of the Deputy Secretaries will be nominated as *Ex officio* Secretary. This ex-officio member is nominated by the Chief Executive Officer.

The above table suggests that the health subject is not discussed at all. In the absence of that, it simply boils down to attending the meeting. As there is a separate Health and Education Sub Committee to look at these matters, it may not be the mandate of the Finance Budget and Planning Committee to discuss the health issues. However, as this committee is accountable in framing the ZP budget, it needs to know the critical social sector like health.

Over all planning of ZP, scrutiny of proposals, ZP finance, annual budget, receipt and payments, income and expenditure statements and audit reports. This Committee does not discuss individual sectors. Members of this Committee during field survey informed that they do not discuss health subject.

About 75% of them said that they had a review of ZP finance at least once in last one year while remaining 25% of them said that they did not have review at all.

Most of the members expressed that they do not have a role in health planning. Among the eight members interviewed, 3 (37.5%) of them said they would review the proposals related to finance.

### Training received

**Table: 4.1.14**

Sl. No	Particulars	Nos
1	No training received/do not remember	8(100%)
	<b>TOTAL</b>	<b>8</b>

As far as training is concerned, all of them said they have not received any training. This could be big hindrance for elected representatives to be effectively functioning and discharge their duty to the fullest possible extent.

One of the districts does not have a committee. The members are not aware of the purpose, objectives for which the committees were constituted. Five Committees have met 4-6 times in a year. But reviews are done only once in a year. Reviews of programmes and budgets are done regularly subject wise. Majority of the times, the Committees review revenue and expenditure of the ZPs. They do not sanction funds. The members have not undergone any training courses pertaining to finance, budget, and planning and resource mobilization. Here again the committees have met in a routine manner to discuss routine matters.

## 4.2 Gram Panchayat level PRIs and officials

### BASIC INFORMATION:

Out of the 80 GP presidents interviewed, 41 of them are men and 39 are women. Among them, 13.75% are illiterate, 15% of them are having primary education, 50% of them are having education between 6<sup>th</sup> standard to 10<sup>th</sup> standard.

### Information on Education, Age and years of service GP Presidents:

**Table: 4.2.1**

	<b>Total(N=80)</b>	<b>Male(41)</b>	<b>Female(39)</b>
<b>EDUCATION</b>			
ILLITERATE	11(13.75%)	5	6
1st to 5th Std	12(15%)	2	10
6th std to 10 <sup>th</sup>	40(50%)	22	18
PUC & above	17(21.25%)	12	5
<b>AGE</b>			
< =25 years	3	1	2
26-35	22(27.5%)	9	13
36-45	32(40%)	18	14
46-55	17(21.25%)	12	5
>55	6	1	5
<b>NO OF YEARS IN CURRENT POSITION</b>			
1 to 2 Years	60(75%)	30	30
3-4 years	17(21.25%)	8	9
>5 years	3	3	0

Most of the respondents (88.75%) are in the age group of 26 to 55 years.

Most of the GP presidents (75%) have spent 1-2 years in the current position

### Special Role of women GP members in health related issues-

Respondents: GP Presidents

**Table: 4.2.2**

	<b>Total</b>	<b>Male</b>	<b>Female</b>
Attending health related programmes, inform women to get benefits from health diff. schemes etc	71(88.75%)	37	34
No special role played by women/no response	5	2	3
Others like visiting health facility, gram sabha and tell women to make use of facility	6	3	3
	<b>80</b>	<b>41</b>	<b>39</b>

Most of them (88.75%) said they attend health related programmes, inform women to get benefits from different schemes etc. But they do not seem to have any special role in addressing health issues at village level.

### Barriers GP President experience in executing their powers-

**Table: 4.2.3**

	<b>TOTAL</b>	<b>MALE</b>	<b>FEMALE</b>
Knowledge	77(96.25%)	39	38
Training	47(58.75%)	21	26
Complete information about roles and responsibilities	78(97.5%)	40	38
Cooperation from the government officials	40(50%)	16	24
	<b>80</b>	<b>41</b>	<b>39</b>

Most of them (96.25%) express that they 'do not have an adequate knowledge'. This is the biggest barrier in executing powers and 97.5% of them said they lack complete information about their roles and responsibilities. Another major hurdle they said that they experience is lack of cooperation from the government officials (50%).



## MEDICAL OFFICER:

Doctors are the first health professional with whom patients from the village come into contact. PHC is the first health facility that patients visit. Hence it is important to understand a bit about the profile of the doctors.

Totally 80 Medical Officers are interviewed across all the PHCs i.e one each from the selected PHCs. Out of them 90% of the Medical Officers have MBBS degree while remaining 10% are having BAMS. Majority of the doctors are men (73.8%) as shown in the following table.

### Gender, Education and Length of services of MOs

Table: 4.2.4

Gender		Educational Qualification	
Male	Female	MBBS	BAMS
59(73.8%)	21(26.3%)	72(90%)	8(10%)
<b>AGE OF RESPONDENTS</b>			
< =30years	26(32.5%)	15(25.42%)	11(52.38%)
31-40	33(41.25%)	28(47.46%)	5(23.81%)
41-50	15(18.75%)	13((22.03%)	2(9.52%)
>51 years	2(2.5%)	1(1.69%)	1(4.76%)
No Response	4	2	2
<b>LENGTH OF SERVICE</b>			
<=1 year	16(20%)	13(22.03%)	3(14.29%)
1-5 years	39(48.75%)	25(42.37%)	14(66.67%)
6-10 years	19(23.75%)	17(28.81%)	2(9.52%)
>10 years	6(7.5%)	4(6.78%)	2(9.52%)

### Age of the respondents:

It is seen from the table 10.1 most of the medical doctors are young and middle aged. About 32.5% of them are less than 30 years of age and remaining 60% are middle aged between 31 to 50 years old. Out of the total 26% of lady doctors, 52.38% are less than 30 years.

### Length Of The Service:

Maximum doctors have less than 5 years of service. About 20% of the interviewed are having less than a year service and 68.75% medical officers are having less than 5 years of service. Experiences show that, people who are young and joined less than a year ago may leave the service any time, either looking for working in multi specialty, private hospitals in cities or considering going for higher studies. Due to shortage of doctors, government is appointing doctors on contact basis. There is every possibility that they do not stay for long and leave the job due to the above mentioned reasons.

## SUB CENTER STAFF

### Information on Education, Years of service of SC staff

Table: 4.2.5

<b>EDUCATION</b>			
	<b>TOTAL(N=158)</b>	<b>Male(4)</b>	<b>Female(154)</b>
UPTO 7 <sup>th</sup> Standard	2(1.27%)	0	2
10 <sup>th</sup> std TO PUC	144(91.14%)	3	141
BA/BSC/B. Ed/Diploma	12(7.6%)	1	11
<b>NO. OF YEARS IN PRESENT POSITION</b>			
Up to 10 years	73(46.20%)	4	69
11 to 20 years	33(20.89%)	0	33
21 to 30 years	43(27.22%)	0	43
>31 years	9(5.7%)	0	9

Most of the sub centre staff is having education between 10<sup>th</sup> standard to PUC

About 46.20% of the staff are having upto 10 years of experience, 20.89 % of the staff are having service between 11 to 20 years and remaining 27.22% of the staff having service 21 to 30 years. Very small fraction of the people are (5.7%) having more than 30 years of service.

### Information on SC staff on membership of VHSC

**Respondents : SC Staff**

**Table: 4.2.6**

	<b>TOTAL</b>
Member of VHSC	155(98.10%)
Not a member of VHSC	3
<b>TOTAL</b>	<b>158</b>

Most of the sub centre staff (98.10%) is also VHSC members.

### View of Sub Center Staff about GP members' involvement in village Health (N=158):

**Table: 4.2.7**

<b>Sl. NO</b>	<b>Activities involved</b>	<b>TOTAL</b>
1	Participate in Health meeting	96(60.76%)
2	Attend to drinking water related issues	21(13.29%)
3	Participate in various health awareness camps	68(43.04%)
4	Attend to issues regarding village sanitation	74(46.84%)
5	Discuss about outbreak of epidemics	11(6.96%)
6	Others	43(27.22%)

Sub centre staff said GP members participate in various activities like health meeting, awareness camps, village sanitation and outbreak of epidemics and also drinking water related issues. However, they have not articulated about GP's involvement in governance. They are fairly aware of their responsibilities with respect to public health and extension issues.

## HEALTH PLANNING AT PHC LEVEL

### Health Planning Process at PHCs

Respondents: Medical Officer, PHC

**Table: 4.2.8**

	<i>Health Plan Discussed</i>	<i>Approval of Health Plan Authority</i>
GP President /GP Members	8	0
THO/MO	77(96.25%)	65(81.25%)
DHO	74(92.5%)	70(87.5%)
CEO of ZP/DPM, RCH officers	3	11(13.75%)
Na	2	0
<b>TOTAL</b>	<b>80</b>	<b>80</b>

It is evident from the above table that, health plans are usually discussed with the officers from the Health Department like DHO/THO. It is hardly discussed with GP President or GP members. Approval of health Plan is done by DHO. Only 13.75% of the Medical Officers said CEO of ZP also approves health plan.

### PERIOD OF HEALTH BUDGET PLANNING:

Health planning and budget process usually happens during the last quarter of financial year i.e from Jan to March, every year (68.75%) and sometimes it spills over till the month of April (16.25%)

### Period of Health Budget Planning

Respondents: Medical Officer

**Table: 4.2.9**

	<b>TOTAL</b>	<b>MALE</b>	<b>FEMALE</b>
Jan to Mar	55(68.75%)	39(66.10%)	16(76.19%)
April	13(16.25%)	9(15.25%)	4((19.05%)
NA/No response	4	4	0
Monthly report sent to THO/DHO every month	5	4	1
Whenever target given/	3	3	0
<b>TOTAL</b>	<b>80</b>	<b>59</b>	<b>21</b>

**Process of health planning:**

Respondents: Medical Officer

**Table: 4.2.10**

	<b>Total</b>	<b>Male</b>	<b>Female</b>
Health planning NOT DONE	17(21.25%)	13	4
Based on the target/guidelines given by the department	20(25%)	14	6
OPD register	49(61.25%)	33	16
Based on previous years diseases/ outbreak etc /Based on various survey	80(100%)	53	27
Others ( based on population, migration, seasonality, etc)	16(20%)	12	4
Feedback from staff/ASHA/GP/Community	34(42.5%)	28	6
<b>TOTAL</b>	<b>80</b>	<b>59</b>	<b>21</b>

*\*Multiple answers*

About 21.25% of the medical officers said that health planning is not done at PHC level, while other 25% said that they strictly adhere to guidelines given by the department. Even though all of them (100%) said they look at previous year's diseases or depend on the survey, they agreed that mostly they make health plans as per the budget and guidelines. During the interview they said demand based planning is not done. Ideally, health planning and execution has to be done at PHC involving various stakeholders like elected representatives, citizens, committee members like VHC/VHSC etc along with PHC staff.

### Institutions involved in health planning:

Respondents: Medical Officer

**Table: 4.2.11**

	<b>TOTAL</b>	<b>MALE</b>	<b>FEMALE</b>
PHC	77(96.25%)	56	21
Sub Centre	74(92.5%)	53	21
Others (VHSC/PDO/NGO/Grama Sabha/ASHA/Pharmacist etc)	2	1	1
Not Applicable as planning is not done	1	1	0
No response	2	2	0
<b>TOTAL</b>	<b>80</b>	<b>59</b>	<b>21</b>

It is evident from the above table; health planning done by PHC and sub center staff. Role of PRIs is not there. Even the VHSC members, constituted under NRHM have no role and they are not involved.

### Scrutinizing/approval authority of health plan

Respondents: Medical Officer

**Table: 4.2.12**

	<b>TOTAL</b>	<b>MALE</b>	<b>FEMALE</b>
DHO	70(87.5%)	50	20
MO	65(81.25%)	47	18
GP/TP/ZP/CEO/DPMO	11	10	0
NA	3	3	0
<b>TOTAL</b>	<b>80</b>	<b>59</b>	<b>21</b>

About 55 (68.8%) members said that PRI members have a role in health budget process of PHCs. But when it is further probed, how they are involved, their involvement is very minimal both in health planning and budget process. Similarly, Medical Officers do agree that most of the cases either DHOs (87.5%) or MOs (81.25%) scrutinize or approve the plans

### GP/ PHC level health Planning

Respondents: GP Presidents

**Table: 4.2.13**

	<b>Total</b>	<b>Male</b>	<b>Female</b>
MO is responsible for health planning	39(48.75%)	14	25
Both GP and MO responsible for Health plan	21(26.25%)	17	4
Both GP & PHC discuss, but PHC/MO responsible for health plan	20(25%)	10	10
<b>TOTAL</b>	<b>80</b>	<b>41</b>	<b>39</b>

It is evident from the above table that MO is responsible for health planning. About 48.75% of the Gram Panchayat Presidents said that Medical Officers are sole responsible for PHC level health planning, while others said they take part in the discussion but Medical Officers finalize the plan.

### GP Presidents' role in planning, monitoring and execution

Respondents: GP Presidents

**Table: 4.2.14**

	<b>Total</b>	<b>Male</b>	<b>Female</b>
Participate in meeting, discuss about issues BUT MO is responsible for taking actions	76(95%)	39	37
Involve in monitoring, visit PHC and check	4(5%)	2	2
	<b>80</b>	<b>41</b>	<b>39</b>

Most of the GP Presidents (95%) said that they only participate in meeting, discuss the issues, but MOs are responsible for taking actions.

### GP/Village/PHC level Health Plan record maintenance-

Respondents: GP Presidents

**Table: 4.2.15**

	<b>Total</b>	<b>Male</b>	<b>Female</b>
Yes – Maintaining	4(5%)	2	2
Not Maintaining. It is maintained at PHC level	76(95%)	39	37
	<b>80</b>	<b>41</b>	<b>39</b>

About 95% of them say they do not maintain any health planning related record with them, it is maintained at PHCs.

## Case Study No:2

### *Who said health is a Technical Subject!!*

As we entered his office the 'typical' image one would have about a Gram Panchayat Adhyaksh came like a flash in our minds. He looked different. 35 year old frail looking Ramesh, the incumbent GP president has completed two terms as GP member, one term as GP President of not so sleepy village Bellatti, a small trade hub located in the backward region of Gadag district. Studied upto 12<sup>th</sup> standard, Ramesh was forthright in listing out achievements he made during his tenure as GP Adhyaksh. He was introduced to us by one of the SHGs with whom we work. SHG members informed that Ramesh was at ease in building relationship with women members which was evident during our short discussion. He recalled various struggles and jathas he undertook in order to get a doctor posted to his village. Contract doctor stayed at Bellatti for as short period as 30 days. He tasted success when a contract doctor was posted to Bellatti PHC.

He was a bit unhappy that GP Presidents are divested from the check signing responsibility of ARS and VHSC accounts. He felt, this decision of the government has with one stroke tainted the GP presidents. Was he happy with the way PHC was functioning? He retorted "PHC will do its job and we do our job" He was blunt enough to say, there was no role for GP in health planning. No records regarding mother and child care were maintained at GP. ASHA members who were present during the meeting said "we furnish information only it is asked." ASHAs have learnt the babudom language quickly. ASHA workers had come to get the expenditure approved. Ramesh after asking series of questions asked them to come with more information.

After carefully listening to Ramesh, we pondered whether GPs should be denied health information because it is "technical" subject.



### GP Health plan by GP Presidents:

Respondents: GP Presidents

**Table: 4.2.16**

	<b>Total</b>	<b>Male</b>	<b>Female</b>
Not aware/ Not using the plan	74(92.5%)	37	37
Providing basic amenities- cleanliness around PHC/drinking water supply to PHCs etc	6(7.5%)	4	2
	<b>80</b>	<b>41</b>	<b>39</b>

Only 7.5% of the GP presidents use the plans in providing basic amenities- cleanliness around PHC/drinking water supply to PHCs etc, while remaining 92.5% of GP presidents are not doing anything.

### Suggestions to improve GP level health plan:

Respondents: GP Presidents

**Table: 4.2.17**

	<b>Total</b>	<b>Male</b>	<b>Female</b>
No suggestion	31(38.75%)	14	17
Need more health staff	19(23.75%)	9	10
Need more grant	18(22.5%)	12	6
Improved infrastructure ( toilet, equipments, good buildings etc)	18(22.5%)	8	10
Need more medicine/drugs	5	2	3
MO taking more responsibility/GP should be more involved/ Signing authority for GP/VHSC members	13(16.25%)	8	5
	<b>80</b>	<b>41</b>	<b>39</b>

About 38.75% of them expressed that they have no suggestions to give. About 22.5% to 23.75 % of them said PHC needs more health staff, grant, improved infrastructure and medicines. About 16.25%of them said that MO should be taking more responsibility and also expressed that GP should be more involved, should have Signing authority for GP/VHSC members etc.

### Drugs planning & utility planning - (N=158)

Respondents: SC Staff

**Table: 4.2.18**

Sl. NO	Drug Planning done	TOTAL
1	Stock medicine during festival season, epidemic outbreak, based on the previous year etc	149(94.30%)
2	Plan for the requirement	6
3	Have the stock as per the MO instruction	9

It is mostly the procurement of drugs as per the previous year requirement or Medical Officer's instructions and there is need for objective planning.

### Extension and education planning :

Respondents: SC Staff

**Table: 4.2.19**

Sl. NO		TOTAL
1	I E S Activity /conduct IEC activity	158(100%)
2	Awareness camp/SHG meeting/house to house visit etc	37(23.42%)
	TOTAL	158

All of them (100%) said that they plan as well as conduct IEC activities. About 23.42% of them also said that they would participate/involve in SHG meeting in the village and they do house to house visit for providing health related information.

Some of the important factors as expressed by both PHCs and GPs are:

- Health planning is done by PHC doctors and SC staff.
- GPs are not involved in the planning process
- GP presidents feel MOs are responsible for health planning.
- Health plans are discussed with THO and DHO, they are not discussed at GP.
- Copies of health plan are not available with GPs

- Health plans are prepared by MO based on previous years OPD register, previous years' disease/epidemic breakouts and feed back from ANMs and ASHAs.
- Drug plans are done based on previous years' experience, disease out break, festival seasons
- IEC activities well implemented.
- Suggestions to improve GP level plan according to GP presidents are- more grant, more staff, improvement in infrastructure, more medicines only a fraction of the respondents have said, GP should be more involved.

## Health BUDGET and FUND

### PRIs role in health budget process at PHC level

Respondents: Medical Officer

**Table: 4.2.20**

	<b>TOTAL</b>	<b>MALE</b>	<b>FEMALE</b>
YES	55(68.8%)	41(69.5%)	14(66.7%)
NO	25(31.3%)	18(30.5%)	7(33.3%)
<b>TOTAL</b>	<b>80</b>	<b>59</b>	<b>21</b>

Even though 68.8% of the respondent medical officers said that PRIs have a role in health budget process, it was more a generic answer. How can any PRI members be involved in health budget process when they are not involved in health planning?

### Preparation of health budget based on health plan

Respondents: GP President

**Table: 4.2.21**

	<b>Total</b>	<b>Male</b>	<b>Female</b>
No/Not aware/done at PHC	74(92.5%)	36	38
Both MO & GP discuss together	4(5%)	4	0
Depending on release of fund, utilize them	2(2.5%)	1	1
	<b>80</b>	<b>41</b>	<b>39</b>

**Budget items for health as per the GP presidents (N=80 multiple answers)**

**Table: 4.2.22**

	<b>Total</b>	<b>Male</b>	<b>Female</b>
No/Not aware/done at PHC/discuss etc	74(92.5%)	37	37
Furniture/materials	4	4	0
PHC building/cleanliness	3	3	0
Purchase of medicines/Delivery fund/VHSC meeting	4	2	2
Salary for night watchman	1	1	0
<b>TOTAL</b>	<b>80</b>	<b>41</b>	<b>39</b>

About 92.5% of the GP presidents are not aware of the budget items. Majority of the GP Presidents are not aware of items to be included in the budget

**GP Presidents operating health fund (N=80 multiple answers)**

Respondents: GP President

**Table: 4.2.23**

	<b>Total</b>	<b>Male</b>	<b>Female</b>
No/Not aware/done at PHC/discuss etc	77(96.25%)	39	38
ARS Fund/VHSC fund	3(3.75%)	2	1
	<b>80</b>	<b>41</b>	<b>39</b>

More than 96.25% of the GP presidents said they do not operate health fund, they only discuss in the meeting. About 3.75% of the GP Presidents involve in operating ARS /VHSC fund.

### Different sources of health fund (N=80 multiple answers)

Respondents: GP Presidents

**Table: 4.2.24**

	<b>Total</b>	<b>Male</b>	<b>Female</b>
Not aware/No idea/Only MO knows	12(15%)	6	6
No fund/ External resource	3(3.75%)	1	2
Govt. and Health Dept	53(66.25%)	24	29
ZP/TP	7	5	2
Collect tax at GP level	7	6	1
ARS Fund/DC Fund	2	2	0
<b>TOTAL</b>	<b>80</b>	<b>41</b>	<b>39</b>

Majority of them said that fund comes from Health Department or Government.

### Funds being handled in last 2 years (N=158)

Respondents: SC Staff

**Table: 4.2.25**

<b>SI. NO</b>	<b>Activities involved</b>	<b>TOTAL</b>
1	Medical equipments like stethoscope, HB meter etc	152(96.20%)
2	Stationeries, furniture, phone bills etc	146(92.41%)
3	Purchase of medicines, phenols etc	136(86.08%)
4	Mother and child, delivery, etc	103(65.19%)
5	Repair work (quarters repair, toilet repair etc)	69(43.67%)
6	Meeting expenses	53(33.54%)
7	Cleaning, sanitation	36(22.78%)
8	IEC materials (pamphlets, wall writing etc)	29(18.35%)
9	Water filter	28((17.72%)
10	Others(miscellaneous)	4
	<b>TOTAL</b>	<b>158</b>

As per the Sub centre staff, funds are utilized for various purposes like Medical equipments (96.20%), Stationeries (92.41%), medicines (86.08%), Mother and child (65.19%), Repair work (43.67%), Meeting expenses (33.54%), Cleaning, sanitation (33.54%), IEC materials (18.35%) etc. SC staff probably are listing items under untied funds.

### Review & Monitoring of staff

Respondents: Medical Officers

**Table: 4.2.26**

	DHO/MO	Health Commissioner	THO
Review/monitoring of PHC staff	80	1	1
Sanctioning leave/write CRs of PHC staff	80	0	0
Review/monitoring of PHC Medical Officer	0	80	0
<b>TOTAL</b>	<b>80</b>	<b>80</b>	<b>80</b>

Review and monitoring of PHC staff in respect of daily work and responsibility is done by the MOs of PHCs. Sanctioning of leave, writing confidential reports of PHC staff are done by MOs but they are reviewed by DHOs. Again, there is no role of PRIs in reviewing and monitoring health staff at PHCs.

### Review the performance of village level health staff

Respondents: GP Presidents

**Table: 4.2.27**

	Total	Male	Female
No/MO will do it	46(57.5%)	23	23
Sometimes will review the work of village level workers /enquire with MO reg progress	34(42.5%)	18	16
<b>TOTAL</b>	<b>80</b>	<b>41</b>	<b>39</b>

About 57.5% of them said, they do not monitor village level health staff. The remaining 42.5% of them said they sometimes review the progress or learn from the Medical officers.

### Authority for checking attendance, sanctioning leaves, writing CRs, Disciplinary actions

Respondents: GP Presidents

**Table: 4.2.28**

	Attendance of PHC/sub Centre staff	Sanction leave	Write CRs	Take disciplinary actions
Yes	3(3.75%)	0	0	0
No	77	80	80	80
	<b>80</b>	<b>80</b>	<b>80</b>	<b>80</b>

GP Presidents do not have powers in sanctioning leave, write CRs or take any disciplinary actions. Only 3.75% of the GP presidents said that they check the attendance of PHC/sub Centre staff.

### Reviewing and monitoring of the performance of Sub Centre Staff (N=158)

Respondents: SC Staff

**Table: 4.2.29**

Sl. No		Review and monitoring	sanctioning leave/write CRs	Fund utilization report	No. of times reviewed in last one year	
1	GP President	3(1.9%)		0	0 times	12 times
2	Medical officer/DHO	158(100%)	158(100%)	158	158	0
3	LHV	30(19%)	0	0	1	157
4	THO	1(0.6%)	0	0		

All of them said that their reviewing and monitoring of performance is done by PHC Medical Officers or DHO. Similarly, they give the fund utilization report to Medical officers. Medical officers only write the CRs and sanction their leave. It is understandable that as these Sub Centre Staff are recruited by Government of Karnataka, MOs are the ones to write CRs. But, not a single time in an entire year, Gram Panchayat President or members reviewed or looked at the fund utilisation report. This clearly indicates PRIs do not have sufficient role in delivery of health care system.

### Views on providing statutory powers to the PRI

When asked PHC Medical Officers about the views on providing statutory powers to PRI in over all planning/Monitoring/Reviewing health delivery system at PHC Level, responses are negative. As many as 67 (83.75%) of them opined that no power should be given to PRI and about 7 (8.75%) of them felt that health activities should be completely delinked from PRI. About 5 (6.25%) of them said that it should be continued with the existing system while very small per cent age (2.5%) of Medical Officers said that PRIs should be bestowed with more powers

Respondents: Medical Officers

**Table: 4.2.30**

	<b>Total</b>	<b>Male</b>	<b>Female</b>
No power should be given to PRI	67 (83.75%)	49	18
Delink health activity from PRI	7(8.75%)	7	0
Giving more powers to PRI	2(2.5%)	2	0
Continue with the existing system	5(6.25%)	2	3
<b>TOTAL</b>	<b>80</b>	<b>59</b>	<b>21</b>

When further asked about the effectiveness of functioning of health care system with complete involvement of PRIs, very small per cent age of Medical Officers (about 5%) felt system is going to be effective, while others are having negative opinion on the issue at varying degree.

### Effectiveness of functioning of health care system with complete involvement of PRIs

**Table: 4.2.31** Respondents: Medical Officers

	<b>Total</b>	<b>Male</b>	<b>Female</b>
1. Very Effective	2(2.5%)	2(3.4%)	0
2. Effective	2(2.5%)	2(3.4%)	0
3. Less Effective	52(65%)	40(67.8%)	12(57.1%)
4. Not effective	18(22.5%)	11(18.6%)	7(33.3%)
5. Can't Say	6(7.5%)	4(6.8%)	2(9.5%)
<b>TOTAL</b>	<b>80</b>	<b>59</b>	<b>21</b>



### Positive experiences about the involvement of PRIs in health

Respondents: Medical Officers

**Table: 4.2.32**

	<b>Total</b>	<b>Male</b>	<b>Female</b>
No Response	11(13.75%)	7	4
Can't say	24(30%)	20	4
Helpful in community mobilization and health awareness	42(52.5%)	32	10
Helpful in programs being effective	16(20%)	13	3
PHC staff will be more alert and punctual	<b>3</b>	<b>3</b>	<b>0</b>
Others ( like it depends on persons, they should be educated etc)	8	5	3

About 13.75% of the Medical officers did not reply regarding the positive experiences while 30% of them are not sure about positive experiences. About 52.5% of them said their involvement would be helpful in community mobilization and health awareness. Very small fraction of people (3.75%) said that with PRI's involvement, PHC staff will be more alert and punctual.

### Negative experiences about the involvement of PRIs in health

While majority of them felt that there will be unnecessary interference / harassment to staff (90%), Political pressure/misuse of power etc (76.25%), misuse of funds (37.5%), Groupism /casteism etc (15%).

Respondents: Medical Officers

**Table: 4.2.33**

	<b>TOTAL</b>	<b>MALE</b>	<b>FEMALEE</b>
Unnecessary interference / harassment to staff	72(90%)	50	22
Political pressure/misuse of power etc	61(76.25%)	46	15
Misuse of funds	33(37.5%)	25	8
No technical knowledge/no knowledge of health system	15(18.75%)	10	5
Groupism /casteism etc	12(15%)	7	5
Others ( negative impact on health system, doctors will leave etc)	7(8.75%)	4	3
Work will hamper	5(6.25%)	4	1

Apart from the various other political pressures, about 18.75% of the medical officers felt that, as PRIs do not have technical knowledge of health system, their involvement will be counterproductive.

### Sharing of information by PHCs to PRIs

Respondents: Medical Officers

**Table: 4.2.34**

	<b>TOTAL</b>	<b>MALE</b>	<b>FEMALE</b>
Yes	70(87.5%)	52(88.13%)	18(85.71%)
No	10(12.5%)	7	3
<b>TOTAL</b>	<b>80</b>	<b>59</b>	<b>21</b>

### Case Study No:3

#### *Blame Game*

When the research team was having discussion with a DHO of one of the sample districts, it emerged that there was one death case due to dengue fever in a village the previous day of our visit. Subsequently, this was reported in the local newspaper. At that time, the DHO was in Bangalore for an official meeting. As soon as she was informed about this case, she called up THO as well as MO of the concerned PHC and instructed them to take the necessary steps immediately to control the outbreak of the disease. She also informed the ZP president about this and explained him about the step being taken by the health department. On the next day [the day of our visit], while DHO was answering to our queries, she received a notice from the CEO stating that there was a death in a particular village and this being published in the local newspaper. The CEO wanted to know the reason behind and also need an explanation from her on this issue. She immediately turned to us and said that this is the reward that one would get by taking prompt measures. She further said that the root cause for the outbreak of dengue fever is because of improper sanitation. If a village does not have proper drainage/sewage facility, then the chances of dengue outbreak would be high and it is the responsibility of the Gram Panchayat to address this issue and not the health department. The PRI system needs to understand this. According to her, if any fatal cases or outbreak of epidemic disease occurs, the first target of the public authority and general public would be the health department. In a PRI system, the elected members would directly blame the head of the institution for any adverse incidences that would occur pertaining to health. This would create mental pressure for doctors as well as other staff to work in such an environment.

### Type of information shared with PHCs

Respondents: Medical respondents

**Table: 4.2.35**

	TOTAL	MALE	FEMALE
Information about health issues/outbreak of diseases	80	61	18
GPs will be kept informed about health plan/discuss in meeting	29(36.25%)	20	9
No response	4	2	2
<b>TOTAL</b>	<b>80</b>	<b>59</b>	<b>21</b>

Majority of the doctors (87.5%) said they shared information with PHC. When further probed, it was found that only general information like health issues or outbreak of diseases is mostly shared. Even though, 29 (36.25%) of them said that GPs are kept informed about the plan, there is no mention of sharing of financial information regarding health issues. Medical officers are also silent on governance issues by PRIs.

### Reasons for not sharing with PRIs

Respondents: Medical Officers

**Table: 4.2.36**

	TOTAL	MALE	FEMALE
No response	2(20%)	2	0
It won't be of use/ no such practice	7(70%)	4	3
Shares information in ARS meeting	1(10%)	1	0
<b>TOTAL</b>	<b>10</b>	<b>7</b>	<b>3</b>

Among the people who said that they are not sharing any information, about 70% of them felt that neither it would be of any use sharing information nor there was any such practice in the past in the system. About 20% of them declined to give any comments on the issue.

#### **Case Study No:4**

##### ***Lack of alignment leading to poor decisions***

In another case, the THO of a taluk under study briefed the research team with an incidence that took place a couple of years back. There was a dedicated surgeon working in the taluk hospital and he was respected by both people as well the other staff for his work ethics. One day, as the doctor was on night duty, he was in the OT attending a patient who was critically wounded. A few outpatients were waiting for this doctor. One among them was a brother of ZP member. It was informed by the doctor that it would be delayed by about an hour or so as he is in OT. At that time, no other doctor was available to attend outpatients. This person – brother of a ZP member did not had the patience of waiting for some more time called upon the ZP member and provided false information that the doctor is unnecessarily keeping them waiting in the lounge.

The ZP member in turn called the DHO and requested him to issue a notice against this surgeon. On the next day, this surgeon got a notice from the DHO. This hurt him deeply and he applied for a transfer and went back to his native taluk. As a result, this taluk hospital lost an opportunity of retaining a dedicated medical professional who had an intension of serving the poor.

### **Summary of responses:**

- With regard to review and monitoring of doctors and health staff, the views expressed by both MOs and GP presidents are on expected lines.
- MOs answered that their performance are monitored by DHO. Sanctioning of Leave, writing CR is with the DHO/Health Commissioner. MOs review the day to day performance of PHC and SC staff
- GP presidents said, they do not have any role in monitoring the work of PHC staff and MOs. They said, they neither sanction leave nor write the CRs of health staff and MOs.
- MOs were very firm in their view that statutory powers should not be given to GPs and even if they are given, it would not be effective.
- MOs could not recollect any positive experience of involving GPs in health activities except in community awareness and mobilisation.
- On the other hand there will be too much political interference and misuse of power. Since health is a technical subject, their involvement will be counter-productive.
- MOs responded that they share information with GPs with regard to breakout of epidemic diseases and health plan. However in previous sections, GPs have informed that they are not provided copy of the health plan and GPs do not keep record of them.
- MOs had reservations about sharing health plan and said there was no such practice.
- Women members of GPs are generally involved in communicating with women to make use of government facilities. They do not have any major role to play.
- One of the important observations made by MOs is with regard to barriers to actively participate. They said lack of knowledge and lack of clarity about their role and responsibilities are major hindrances for active participation. They also listed lack of training as limited their active participation.

### **Conclusions and Recommendations:**

- GPs presidents and members have enough scope and opportunity to actively participate in the functioning of health system in GPs. They have responsibility to monitor SCs and Anganwadis. They can demand information from MOs. MOs, cannot refuse to provide information. When they refuse, it can be reported to ZP and DHO. Access to information is power and empowerment.

- GP presidents have a perception that handling a bulky budget enhances their importance. Further executing infrastructure works like roads and drainage construction or asking for construction of SC/PHC centres though not unimportant issues, they bring visibility. These perceptions need to be changed.
- Non finance functions which are more governance related are equally important. Visiting PHCs and SCs to review about cleanliness, water and power availability, attendance of doctors and health staff, conditions of equipments, drug stock outs and interacting with patients and sending their feedback regularly to TP/ZP/DHO can improve the performance of PHCs/SCs.
- They need not hanker on getting statutory power to control and regulate the doctors and health staff.
- These efforts will bring GP closer to the community and win their confidence.
- As said in earlier sections, GP presidents and members should be given training programmes to understand their roles and responsibilities and utilise opportunities available within the PRI Act to improve the quality of health services.
- Women members of GPs should be trained and actively involved in maternal health issues, since women, children and aged form a major component of outpatients and inpatients who visit PHCs.
- MOs and health staff should also be provided sensitization training programmes to understand the roles and responsibilities of PRI institutions.

## SECTION V

### NATIONAL RURAL HEALTH MISSION

In the 12th Five Year Plan period, the Union Government intends to consolidate the gains and build on the successes of the Mission to provide accessible, affordable and quality universal health care, both preventive and curative, which would include all aspects of a clearly defined set of healthcare entitlements including preventive, primary and secondary health services.

**At the national level, the targets would be as under:**

- Reduction of MMR to < 100 per 100000 live births
- Reducing IMR to < 27 per 1000 live births
- Reduction in NMR to < 18 per 1000 live births
- Reducing TFR to 2.1
- Elimination of Filaria – in all 250 districts; Kala-azar in all 514 Blocks and Leprosy in all districts
- Reduction in TB prevalence and mortality by 50%
- Reduction in Annual Malaria incidence to <1/1000 pop.
- Reduction in JE mortality by 50%
- Sustaining case fatality rate of less than 1% for Dengue

For realisation of the goals of the Mission, priority is given to involve the PRI structure and have in place community based monitoring system. At PHC, CHC, districts hospitals, independent institutions like ARS/RKS are established. They are provided with an untied fund which can be used as per the judgement of the management societies. Another important village institution is the VHSC. This is claimed to be the main foundation for building up the community based plan and monitoring. Another innovation of NRHM is providing untied funds and grants to VHSC.

#### NRHM SOCIETY

##### Planning:

The questionnaire was administered to the District Programme Manager/Deputy District Programme Manager. Most of the answers to the Questions were informative in nature. They explained the functioning of the NRHM Society. Most of the programme officers have Management background and are experienced. With regard to health planning and involvement of functionaries and elected representatives they have varied answers. Most of them have answered that District Health Society, DHO and CEOs are involved. They claimed that while preparing health plan, parameters like disease mapping, drug demand, staff needed, utilities needed, extension and training requirements infrastructure needed are considered.



### **Case Study No:5**

#### ***Can cold be cured by cutting a running nose?***

He was studying the X ray of a patient. Dr. Hallemmanavar had converted a small corridor of his house into a clinic. It had two parts connected by a door. One portion was the examination room, just enough for the patient and the doctor to sit across. The other portion was patient waiting room. Dr. Hallemmanavar had just returned from a meeting. Couple of patients were waiting for him. Having done his post graduation, he had put in a number of years of service in rural areas. Currently he is working in Suranagi PHC in Gadag district for the past eight years. With the initial ice breaking talks, the discussion centered on his relationship with the local GP. Is it cordial? Is there good coordination? He narrated several incidents to prove his point that GPs do not cooperate and they should not be given power regarding health subject. As the summer was approaching and water scarcity looming large on the surrounding villages, Hallemmanavar suggested to the GP to inspect all the water pipe lines to avoid possible water contamination. He had spotted a couple of them. But his advice was not heeded. Another incident related to augmenting water supply to PHC. With great difficulty and lot of convincing he had got a bore well dug and pump installed. According to the doctor, as the term of the GP president came to an end, the president got the pump removed. Was there any positive side of his relationship with GP? Doctor had none to tell.

While concluding his extended narration, doctor echoed the decision of the government, withdrawing the power of signing of cheques of untied funds from GP president. The issue was of 'Commission'. Is it also true that due to the system of PRI, such incidences are visible to the public and get noticed? It is not to say corruption does not take place at other levels. Again it was an issue of perception and ego. As the adage goes, 'Cold cannot be cured by cutting a running nose'

## **Role of PRI**

It was rather a straight answer from every District Project Manager that PRIs have no role in planning, budgeting and approvals. They do monitoring of programmes. They were not clear about the specific role in monitoring.

## **Untied Funds:**

The necessity of untied funds have been felt due to the unavailability of funds for undertaking any innovative centre specific need-based activity, as the allotment of funds to the states has traditionally been of the nature of tied for implementing a particular activity/ scheme and this hardly left any funds for specific public health facilities (Nandan, 2008-09). This fund, as the name suggests, need not be spent on any pre determined purposes. It can be spent on the felt needs of the local institutions. Each CHC/THH will get Rs. 50,000, P

HC will get Rs.25,000 and SC and VHSC will get Rs. 10,000 each annually.

All the officers are well aware of the constitution of various hospital management committees and funds handled by them. In respect of utilising untied funds, the typical answer was that NRHM guidelines were followed. One respondent said funds are spent as per the activity plan prepared. This is one of the important components of NRHM, much publicised, but the answers were well guarded.

We also noticed in the field that in many cases, even though they are untied, in true spirit they are not really untied. Sub centres and VHSC seems to wait for the PHC Medical officers' instructions and permission to spend the money rather than, articulating the felt needs and spending on them. In one of the PHCs, in an informal discussion, Medical Officer said that untied money was used to make a proper approach road to PHC on the occasion of Chief Ministers' visit to the facility.

### **ROGI KALYAN SAMITHI (RKS)**

Rogi Kalyan Samiti (Patient Welfare Committee) / Hospital Management Committee (HMS) is a simple yet effective management structure. This committee, which would be a registered society, acts as a group of trustees for the hospitals to manage the affairs of the hospital. It consists of members from local Panchayat Raj Institutions (PRIs), NGOs, local elected representatives and officials from Government sector who are responsible for proper functioning and management of the Hospital / Community Health Centre / FRUs. RKS / HMS are free to prescribe, generate and use the funds with it as per its best judgment for smooth functioning and maintaining the quality of services.<sup>7</sup> In Karnataka, RKS is headed by President of TP.

To understand the formation of the committee, their functioning and role in governance, one member of RKS (ROGI KALYAN SAMITHI) from each of the 16 selected CHCs were interviewed.

The details of the analysis are given below-

#### **Formation of RKS**

**Table: 5.1**

<b>Sl. No</b>	<b>Year</b>	<b>No. of RKS formed</b>
1	2005-06	1(6.25%)
2	2006-07	0
3	2007-08	14(87.5%)
4	2008-09	1(6.25%)
	<b>TOTAL</b>	<b>16</b>

It is seen from the above table that only during year 2007-08, most of the committees formed. About 87.5% of the Rogi Kalyan Samithi (RKS) are formed during that year.

#### **No of meetings of RKS in last one year**

**Table: 5.2**

<b>Sl. No</b>		<b>Nos</b>
1	No meeting	3(18.75%)
2	One time	2(12.5%)
3	2 times	3(18.75%)
4	3-4 times	1(6.25%)
5	6-8 times	4(25%)
6	Every month (12 times)	3(18.75%)
	<b>TOTAL</b>	<b>16</b>

<sup>7</sup> NRHM guidelines

As per the guidelines, Governing body and executive body of RKS is supposed to be meeting on quarterly/monthly basis respectively and discuss the issues regarding hospital maintenance and improvement of the health system. In this study, we have not differentiated between executive members and general body and interviewed one member from each of RKS.

Some of the RKS (18%) have not met even once, though all them were established not later than 2008-09. Only three RKS (18%) have met 12 times in a year. Others have met two to eight times in a year. In spite of meeting, only 12.5% of RKS have discussed fund utilisation, programme monitoring, 25% of them have discussed about institution delivery, similar number of RKS discussed only NRHM guidelines. About 37% of these societies had no discussions.

### Issues discussed in RKS

**Table: 5.3**

Sl. No	Topics Discussed	Nos
1	Nil	6(37.5%)
2	NRHM guidelines	4(25%)
3	Institutional delivery, Immunisation, women health etc	4(25%)
4	Fund utilisation, program monitoring	2(12.5%)
		<b>16</b>

They have general discussions on repair and maintenance of building, repair of equipments, repair of water pump, cleanliness, purchase of miscellaneous items etc. With regard to improvement of health system, members are involved in awareness related activities, health camps (54%) and guidance regarding mother and child health care (80%). RKS seem to be working satisfactorily with regard to health extension and communication. But the RKSs have not performed as independent management Committee of hospitals. Accountability is yet to be realised.

It is gratifying to note that RKS has also discussed about MMR, immunisation, reproductive health fund and programme monitoring. It is generally construed that RKS is just meant for discussing about spending of untied fund. As per the guidelines, RKS has to function like an NGO and not as a government society. However our discussions with the RKS members did not reveal this point.

## Role of RKS members

**Table: 5.4**

Sl. No	Role	Nos
1	Nil	14(87.5%)
2	Monitoring	2(12.5%)
		<b>16</b>

## Funds handled and Resource mobilisation:

As per the NRHM guidelines, each of the CHC will be provided with Rs. 1,00,000 per year as an Annual Maintenance Grant (AMG). This amount can be used for maintenance and upkeep of the facility building. Apart from this, each CHC also will be receiving Rs. 50,000 as an untied fund for local specific needs and also take up any innovative approach. It could also be used for any urgent needs like purchase of additional medicines in case of emergency. Apart from this, RKS is also authorised to keep any user fee at the institutional level for its' everyday needs.

## Fund Utilisation by RKS

**Table: 5.5**

Sl. No		Nos
1	No fund handling	12(75%)
2	NRHM untied fund	4(25%)
		<b>16</b>

## Resource mobilisation by RKS

**Table No: 5.6**

Sl. No		Nos
1	Not aware	14(87.5%)
2	User fee	2(12.5%)
		<b>16</b>

Majority of them (75%) said they are not aware of any funds. They feel it is health officials' domain. Even among the people who said they were handling fund, it is about NRHM untied fund. Here also, they expressed that they do not have any role in governance or decision making process in utilising those funds. It was observed from our interactions that non government officials and elected representatives have not taken keen interest in the RSK meetings. They felt it was the responsibility of the health officials. This may be due to lack of training and understanding. The committee has not made any plans for expenditure of untied fund. It has not been able to work like an NGO independent from the government. Otherwise, RKS could have been an ideal platform for the PRI and elected members to assert their role and work for the betterment of community health.

When we interacted and had interview with RKS members, they are not involved in any fund mobilisation. Besides having no role in finance, members are also not aware of mobilising resources (87.5%). Among two members (12.5%), who said that they are aware, they only know about the user fee being collected in hospitals. But, they are not aware that they could take part in resource mobilisation and constructively use them for health infrastructure improvement. Also, they are not aware about how much user fee being collected and how the user fee collected being used.

**Comments on the RKS committee and involvement:**

**Table: 5.7**

Sl. No		Nos
1	Good	2(12.5%)
2	Not answered	14(87.5%)
		<b>16</b>

The fact that most of the members have not answered about their involvement; it reaffirms the fact that these committees are formed for name sake.

**Training received:**

**Table: 5.8**

Sl. No		Nos
1	Immunisation/delivery	2(12.5%)
2	Not aware/Not received	14(87.5%)
		<b>16</b>

RKS members do not visit villages and when they visit health camps discuss with ASHA. They are not aware of their roles and they do not participate in a responsible manner. They have not undergone training in issues related to health governance, roles and responsibilities.

Recommendations:

- RKSs have to meet regularly.
- RKSs have to plan in advance for untied funds
- RKS has to function like an independent NGO
- Proper training and capacity building programmes have to be conducted for the members both in conduction of meetings and on governance and accountability.
- RKS members have to be trained in rudiments of accounts, planning and monitoring.
- They should visit health units and interact with public and patients.
- They should elicit suggestions from the public.

### ARS MEMBERS

Totally 80 ARS members are interviewed ( i.e. one member/PHC, out of which 70% of them have studied upto 10<sup>th</sup>/PUC, about 22.5% of them are having college degree.

#### Details on ARS members (Education, Gender, &Age)

**Table: 5.9**

<b>EDUCATION:</b>			
	<b>TOTAL</b>	<b>MALE</b>	<b>FEMALE</b>
UPTO 7 <sup>th</sup> Standard	6(7.5%)	1	5
10 <sup>th</sup> std TO PUC	56(70%)	9	47
BA/BSC/B. Ed/Diploma	18(22.5%)	10	8
<b>AGE</b>			
20-30	12(15%)	3	9
31-50	42(52.5%)	14	28
>51	24(30%)	3	21
No response	2(2.5%)	0	2

About 67.5% people are from age group between 20-50 years of age.

**Year of ARS formation:**

**Table: 5.10**

YEARS	2007	2008	2009	2010 & 2011	TOTAL
	24	38	15	3	<b>80</b>

Most of these ARS are formed between 2007 and 2009.

**No. of times ARS met in last one year:**

**Table: 5.11**

No of times ARS met	Members (Frequency)
0	1
1-4	44 (55.1%)
5-8	28(35.1%)
9-12	7(8.8%)

About 55.1% of the members said they have quarterly meeting, while another 35.1% said that they are meeting every once in 1.5 to 2 months (5-8 times per year) and 8.8% of them said that they have meeting almost every month (9-12 months). ARS are having frequent meetings

**ISSUES DISCUSSED IN THE MEETING:**

Mostly the issues revolved around utilization of fund for various activities in hospital management. The main issues discussed are: Repair of buildings/equipments etc (100%), repair of electrical equipments (77.5%), water supply sump repair (76.25%), painting of buildings, and purchase of equipments-medical and general / electrical items like camera, TV, and medicines. Issues discussed are in general as per the guidelines. They are varied and wide.



## Issues Discussed in the meeting

Respondents: ARS members

**Table: 5.12**

	<b>TOTAL</b>	<b>Male</b>	<b>Female</b>
Repair of buildings/equipments etc	80(100%)	19	63
Surgical equipments/stethoscope etc	64(80%)	5	59
Electrical equipments repair like fridge/TV	62(77.5%)	13	49
Water supply/repair of sump/filter etc	61(76.25%)	15	46
Sanitation/cleanliness/waste management etc	59(73.75%)	14	45
Painting of PHC building/purchase of curtains etc	57(71.25%)	11	46
Purchase of camera/TV/printer etc	42(52.50%)	10	32
Purchase of medicines	42(52.50%)	10	32
Purchase of equipments chemicals to PHC	41(51.25%)	15	26
Labour room baby warmer/ reduces heat	40(50%)	10	30
Purchase of miscellaneous things like ladder, CFL bulbs, lockers, Fan etc	39(48.75%)	9	30
Furniture/chairs/cots	37(46.25%)	2	35
Health camps/vaccinations/health day celebrations etc	37(46.25%)	13	24
Fund utilization/honorarium etc	24(30%)	8	16
Name plate/board etc	21(26.25%)	4	17
Oxygen cylinder	17(21.25%)	5	12
IEC materials	17(21.25%)	5	12

### Role ARS members in improving the health services:

Respondents: ARS members

**Table: 5.13**

	TOTAL	Male	Female
Guidance regarding health-nutrition, child & mother health etc	64(80%)	21	42
IEC activities- health camps etc	43(53.75%)	10	33
Through meetings- SHG members, pregnant women etc	18(30%)	2	16
Others activities like monthly check up, injection to patients etc	6(7.5%)	3	3
<b>TOTAL</b>	<b>80</b>	<b>20</b>	<b>60</b>

When ARS members are asked about their possible role in improving health system in the region, they mainly came with service related and awareness related activities like Guidance on health-nutrition, mother and child health etc (80%), IEC activities- health camps etc (53.75%), meetings with community (30%) etc. ARS members have expressed their interest to involve in activities other than repair and maintenance, such as health and nutrition, mother and child health, health camps and awareness camps, meeting SHG members, pregnant women. This is a welcome come.

#### **Conclusions :**

- ARS are meeting regularly. They discussed wide and varied issues as per the guidelines.
- Besides they are interested in MMR, IMR issues, conducting awareness and health camps.
- Even though wide ranging issues are discussed, ARS have not prepared plans for spending untied funds.

Overall performance of ARS is satisfactory.

#### **Recommendations :**

- ARS members should be trained in understanding and articulating maternal and child health issues.
- They should undergo training in proper planning for spending untied funds.
- ARS members should be encouraged to meet the village community, especially women and *children*.

## Village Health Sanitation and Committee<sup>8</sup>

One of the major thrust and component of NRHM is to build the capacity of community and also empower them in health and sanitation matters. Major thrust has been given for VHSC which intends to realise these goals. It is a village level institution where in community, local health workers and PRI members come together. Further its importance has increased as it is considered as a sub-committee of GP.

Important roles are:

1. VHSC is responsible for the overall health status of village. It will take cognisance of health and nutrition problem of the community and provide solutions. It will prepare village health plan.
2. It will supervise and discuss house hold survey conducted by ANM and ASHA. VHSC keeps village health register and prepare village health information board. This will be placed at important locations in the village
3. VHSC will enable public dialogue twice year at MO office where in villagers will debate health related issues with MO.
4. VHSC will supervise conduction of awareness camps, mother day and nutrition day.
5. VHSC will supervise SC.
6. VHSC will have monthly review meeting and register the proceedings.

### Constitution of VHSC

Respondents: GP President

**Table: 5.14**

Yes	78(97.5%)
No	2
Total	80

In most of the places (97.5%) of the places, Village Health and sanitation committees are formed.

<sup>8</sup> More details about roles of VHSC are available at [nrhm.gov.in](http://nrhm.gov.in)

### Number of times VHSC met during last one year

Respondents: GP President

**Table: 5.15**

	<b>Total</b>	<b>Male</b>	<b>Female</b>
No response	2	0	2
1 to 3 times	37(46.25%)	17	20
4 to 6 times	36(45%)	21	15
8 to 12 times	5	3	2
	<b>80</b>	<b>41</b>	<b>39</b>

Though frequent meetings have been conducted as per the guidelines, monthly meetings have to be conducted.

### Issues discussed in VHSC meeting (N=158)

Respondents: SC Staff

**Table: 5.16**

<b>Sl.No</b>	<b>Topics discussed</b>	<b>TOTAL</b>
1	Safe & clean drinking water/water tank cleaning/chlorination etc	154(97.46%)
2	Village anganawadi/school surrounding cleaning/Drainage cleaning/garbage cleaning	151(95.57%)
3	Pregnant women, JSY kits etc	126(79.75%)
4	Village environment , health, hygiene	116((73.42%)
5	Meeting with pregnant women, JSY/ Madilu kits, precautions etc	115(72.78%)
6	Meeting with GP/SHG/village leaders regarding fund utilization and activities	106(67.09%)
7	General topics like nutrition, immunization, road repair, wall writing etc	106(67.09%)
8	Child health, baby show, awareness camp etc	69(25.95%)
10	Precautions for epidemic outbreak during festivals	18(11.39%)
11	Public toilet cleaning and repair	10(6.33%)
	<b>TOTAL</b>	<b>158</b>

**The issues discussed at VHSC meeting (N=80 multiple answers)**

Respondents: GP President

**Table: 5.17**

	<b>Total</b>	<b>Male</b>	<b>Female</b>
Village cleanliness/sanitation	70(87.5%)	41	29
Health programme /camps/contagious diseases	38(47.5%)	21	17
Drinking water	39(48.75%)	23	16
Drainage cleaning /use of toilet	32(40%)	16	16
Medicine purchase	8	6	2
Others (Road repair, street light etc)	12	7	5
	<b>80</b>	<b>41</b>	<b>39</b>

Both GP presidents and SC staff have given similar responses in respect of village cleanliness, sanitation, drinking water road repair. However, SC staff has listed other issues such as mother and child health, nutrition, immunisation, wall writing, JSY, Madilu kits, meeting GP/SHG leaders, fund utilisation. Probably due to lack of articulation GP presidents could not have elaborated the issues. However they seem to be aware of these issues.

**Village health plans**

**Various Planning done at VHSC (N=158)**

Respondents: SC Staff

**Table: 5.18**

<b>Sl. NO</b>	<b>Planning done</b>	<b>TOTAL</b>
1	Larva survey/ Advance larva survey	81(51.27)
2	Do advance survey about-Chicken gunya	55(34.81)
3	Do advance survey about-Dengue fever	54(34.18%)
4	Do advance survey about sankrami carogagalu	41(25.95%)
5	CNA Survey (household)	26(16.46%)
6	Do advance survey about-Malaria	10(6.33%)
7	Other surveys like leprosy, diarrhea, TB, Cholera, RFS, elephant foot, polio etc	32((20.25%)
	<b>TOTAL</b>	<b>158</b>

According to SC staff different plans are done for various health related surveys like larva survey (51.27%), Chickengunya (34.81%), Dengue fever (34.81%), epidemics, household and community need assessment surveys, malaria etc. Other plan they do is drugs & utility planning like Stock of medicine during festival season, epidemic outbreak, based on the previous year etc (94.3%) and Extension /education planning like IEC activity.

During our recent field visits when interviews were done with many SC staff and GP members, we observed that, most of these surveys are done in detail by ANM with the support of ASHA workers. Collected data are tabulated and sent to MO. Survey formats have been developed for MCH and need assessment survey. Data collected apparently were not discussed at VHSC. No documents are available with GP. VHSC being considered as sub committee of GP, invariably the survey details and any individual plans done should have been part of GP documents. Since ANM collects data on various National programmes, which are listed in the table, they also have to perform these functions apart from PRI/NRHM activities They also informed that village health register was not maintained at most of the GPs and very rarely health information boards are placed at important places in villages. However, now due to the familiarity of NRHM villagers access this information from ASHA or ANM. Except the Birth & death register and untied fund register other registers were not with the VHSC. Neither they had the proceedings of the Dialogue committee and monthly report of ANM. There was no evidence of ANM being supervised by VHSC.

### **Conclusions:**

- Though monthly meetings of VHSC are not held, they have met frequently.
- The GP Presidents and members as well as SC staff seem to have understood broad issues that are discussed in VHSC meetings.
- Village Health planning in an itegrated manner is not done. Plans are drawn from individual issues covered in the survey mainly MCH and community needs.
- Awareness camps on nutrition, monther and child health are conducted.
- IEC campaigns are undertaken regularly
- Villagers are aware of various government schemes.
- Village health plans are not kept at GPs. They are sent to MOs of PHCs.
- Village health register is not maintained. Village health information board is not kept at strategic places in villages
- Public dialogues are not conducted and their reports are not available with GPs.
- There are no evidences to show that maternal and neonatal deaths are discussed and proper records are maintained

- ANMs do not submit fortnightly report and two months plan to GP/VHSC
- GP is not supervising SCs.
- ANM and SC staff does not want to work under the supervision of VHSC/GP
- They are now reporting and working directly under the supervision of MOs

**Recommendations:**

- *VHSC should be considered as a Sub Committee of GP.*
- *All records of VHSC should be kept with the GP.*
- *An integrated village health plan should be prepared and discussed. It should be kept at VHSC/GP.*
- *An integrated GP health plan should be prepared. After discussion and approval, they can be sent to MO and also TP.*
- *Public dialogue at MO office should be held regularly and proceedings made available with VHSC*
- *Village health register should be prepared and kept at VHSC*
- *Similarly village health information board should be prepared at displayed at important places in villages.*
- *Maternal and neonatal deaths if happened should be discussed, brought to the notice of MO and records should be kept at VHSC/GP*
- *GP should strictly supervise functioning of SCs as it is part of the activity planning.*
- *In general SC and PHC staff do not want to be under the control and supervision of GP. This could probably an ego issue. Efforts should be made to solve this issue.*
- *GP presidents are not aware of the available provisions to be completely in charge of VHSC, supervising of SC nor have they exercised these powers.*
- *They should be provided training in this regard.*
- *GPs take efforts to build trust between itself and the SC staff. They should bring an environment of transparency in conducting the affairs of VHSC.*

## SECTION VI

### OUT PATIENT

Quality of any service is mainly dependant on the extent to which the customers or receipients of services are satisfied or dissatisfied. InervIEWS with outpatients and inpatients of a health facility could be one form of recording customer satisfaction.

Exit interview with 719 out patients are done across 80 PHCs out of which 340 are men and 379 patients are women.

**Details on Outpatients profiles( Age, education, gender, occupation, place, distance travelled)**

**Table: 6.1**

<b>Age of the respondents</b>			
<b>YEARS</b>	<b>TOTAL(N=719)</b>	<b>Male(340)</b>	<b>Female(379)</b>
< =20 years	90(12.52%)	41	49
21-40	341(47.43%)	140	201
41-60	188(26.15%)	96	92
>60	100(13.91%)	63	37
<b>Education level of Respondents</b>			
No response	184(25.59%)	64	120
Illiterate	76(10.57%)	34	42
1 <sup>st</sup> to 10 <sup>th</sup> Std	370(51.46%)	179	191
PUC & above	89(12.38%)	63	26
<b>Occupation of the respondents</b>			
Agriculture/ Agri. Labour / labour	443(61.61%)	247	196
House wife	134(18.64%)	0	134
Dhobi/carpenter/weaver/blacksmith /business/driver/tailor etc	65(9.04%)	41	24
Students	43(5.98%)	27	16
Office work/teacher etc	26(3.62%)	17	9
<b>Place of the patients</b>			
Same Village	463(64.39%)	208	255
Different village	256(35.6%)	132	124



<b>Distance travelled by Outpatients to PHCs</b>			
No Answer	25(9.75%)	14	11
1-2 km	76(29.69%)	41	35
3-5 km	98(38.28%)	48	50
6-10KM	40	19	21
>10 km	17	8	9

Most of them who are interviewed are of age group between 20 to 60 years. However, it does not necessarily indicate that only this age group of people attend the PHCs, it could be easy for interviewer to get information. Generally women, children and aged visit the PHCs for health ailments. This is also evident from the above tables. Women also accompany their children to the PHCs.

When it comes to the educational profile, majority of them are primary and secondary education.

Majority of them who visit PHCs are either from agriculture or agriculture labour background. Remaining people are either homemakers or pursuing subsidiary occupations like carpentry, blacksmith etc. The respondents could be socially and economically vulnerable section of the community.

### Reasons for visiting the PHC

**Table: 6.2**

	<b>Total respondents</b>	<b>Male</b>	<b>Female</b>
Near to home	614(85.40%)	285	329
Good service	681((94.71%)	318	363
Its free/ Less expensive/can't afford to go to private hospital	450(62.59%)	211	239
Minor ailment / For first aid treatment	604(84.01%)	291	313
Recommended by others	61	22	39
Typhoid	1	0	1
Doctors available 24x7 - 365 days	1	1	0
	<b>719</b>	<b>340</b>	<b>379</b>

- Multiple answers

Main reasons for people preferring PHCs are nearness to home (85.40%), minor ailment/near to home (84.01%) and less expensive (62.59%).

#### Place of the outpatient:

About 35.6% of the patients come from different villages other than where PHC is located. Among these people who come from different places, 38.28% people come from 3-5 km distance and 29.69% come from 1-2 km distance.

#### Physical condition of OPD facility:

**Table: 6.3**

	OPD Space	Seating Arrangement	Fan & Ventilation	Drinking Water	Toilet
Excellent	50(7.0%)	31(4.3%)	27(3.8%)	16(2.2%)	17(2.4%)
Good	622 (86.5%)	627(87.2%)	575(80.0%)	563(78.3%)	443(61.6%)
Bad	47(6.5%)	61(8.5%)	117(16.3%)	140(19.5%)	259(36%)
	<b>719</b>	<b>719</b>	<b>719</b>	<b>719</b>	<b>719</b>

It is seen from the above table, that overall physical conditions like OPD space (93.5%), seating arrangements (91.5%), Fan & ventilation (83.8%) are satisfactory to patients. However, 19.5% of the Out patients said drinking water situation is bad and 36% of them said toilet facility is bad. It is a cultural practice in rural parts of Karnataka to speak good words about services even when they are not satisfactory whenever outsiders visit their villages. They do not make negative comments. This being the case when the reactions are very good or good, they should be considered with a bit of caution. Even then also there are adverse opinions with regard to drinking water and toilet facility.

Probably these facilities could have been even better if GPs/VHSCs had regularly visited PHCs as these activities (as per activity chart) are for the GPs to execute.

### Medicine dispensation to outpatients at PHCs:

**Table: 6.4**

	No. of patients received complete medicines	Purchased completely from outside	Partial purchase
Yes	460(64%)	35(4.9%)	275(38.2%)
NO	259(36%)	684(95.1%)	444(61.8%)
	719	719	719

Sufficient availability of the medicines at PHCs is always a concern. It is one of the main criteria for analysing the quality of services. Several studies and also NSSO data have revealed that purchase of drugs form a major portion of the outpocket expenses incurred in India. One of our studies has also made this observation<sup>9</sup>. 36% of the patients said that they do not get fully prescribed medicines. About 5% of the patients buy medicines completely from outside. About 38.2% of the people said apart from getting medicines at PHCs, they also buy from outside.

### Money spent on medicines:

**Table: 6.5**

	No of respondents	Male	Female
Up to Rs. 50	133(52.36%)	68(48.92%)	65(56.52%)
Rs. 51 to 100	104(40.94%)	64(46.04%)	40(34.78%)
Rs.101 to 150	10(3.94%)	4((2.88%)	6(5.22%)
Rs.151-200	7(2.76%)	3(2.16%)	4(3.48%)
NO RESPONSE	4		
	<b>259</b>	<b>141</b>	<b>117</b>

Approximately half of them (52.35%) said they are spending money upto Rs 50 is common per visit apart from their travel and other incidental expenses. About, 40.94% of the people said they spend money upto Rs.100 towards purchase of medicines. There is clearly a scope for addressing this issue.

<sup>9</sup> Following the Public Health Delivery Trail- A worm's eye-view of the health spend. A Study by IDPMS, Bangalore(2008)

## No of outpatients complained regarding not satisfactory conditions at PHCs

**Table: 6.6**

	No of respondents	Male	Female
Yes	23(3.2%)	13	10
No	696(96.8%)	327	369
<b>TOTAL</b>	<b>719</b>	<b>340</b>	<b>379</b>

Whenever, situation is bad, only 3.2% of the patients said that they complained. In any service providing system, provisions should be made for the recipients to record their grievances. It could be through a complaint box, complaining to the local elected representative, or in the current situation it could be to the VHSC. Issues could also be raised in Jan Sunvai. Since Jan Sunvai has not been conducted, this does not arise. During field work it was observed that complaint boxes were not available. Among the people who gave complaints, majority of them seemed to complain to Medical Officers or Local leaders. The reasons could be varied. It could be due to lack of accessibility to elected representatives, or disconnect between GP and community, VHSC is not taking responsibility. If there had been a proper coordination between GP/VHSC and PHC, things could have been different. Shortage of doctors and absenteeism of doctors and support staff is a major concern.<sup>10</sup> The same study also has highlighted lack of supervision from DHO. If local elected institutions were given responsibility of monitoring, quality of services could have been improved.

**Table 6.7**

	No of respondents Gave complaint (N=23)	Male	Female
PHC MO	10	5	5
GP President/ GP Member	4	2	2
MLA	3	3	0
Local Leader	14	8	7
Village Head	1	1	0

<sup>10</sup>Sadananda S, Bhat Sudha (October 2011)–'Where have they gone?-A study on the absenteeism of doctors and support staff in Primary Health Care centers)

## Details of Complaints made by Outpatients

### Participation of out-patients in different health related events:

**Table: 6.8**

	No of respondents	Male	Female
Local health camps/Immunization	612(85.12%)	263	349
Polio eradication campaigns	224(31.15%)	85	139
No/ Not participated/No response	134(18.64%)	67	67
Access to safe delivery camp	68(9.46%)	9	59
Village Health and nutrition day	51(7.09%)	29	22
Others (Blood donation, Eye camp, etc)	8(1.11%)	7	1
<b>TOTAL</b>	<b>719</b>	<b>340</b>	<b>379</b>

Most of the outpatients (85.12%) participate in local health camp or immunization programme. Other events attended being Polio eradication campaigns (31.15%), Access to safe delivery camp (9.46%), Village Health and nutrition day (9.46%) and others (Blood donation, Eye camp, etc)

Apart from the above issues which have impact on the quality of services some of the other issues which could have a bearing on quality of services at the village level are:

- Jan Sunvai or Public Hearing
- Information not shared with the GP/VHSC
- VHSC not maintaining village health register
- Health information board not displayed at important places in the village
- Monthly meetings of VHSC not being conducted regularly
- Records of meetings not maintained at VHSC
- VHSC still not considered as sub committee of GP.
- GP/VHSC members' not visiting health centers frequently for monitoring purposes.

All the above issues are part of transparent and accountable governance. Keeping GPs away from these activities, they are not able to monitor the services as well as performance of the health functionaries. If GPs had been part of all these processes, there could certainly have been an improvement in the quality of services.

## Conclusions

- *There should be a joint committee consisting of GP president, women members, VHSC members and local NGOs should be formed to visit PHCs regularly. The Committee should do physical inspection and interact with patients with regard to quality of services.*
- *Special attention should be given to reduce the stock out period for medicine and prescription should be avoided.*
- *Issues regarding availability of doctors and support staff, disposition of health staff and MOs towards patients should be discussed.*
- *A report should be prepared and sent to TP/ZP/DHO. A copy of the report should be kept at GP for village community to access*
- *Jansunvais or social audits should be mandatorily conducted*
- *All records pertaining to VHSCs should be kept at GP.*
- *Village health register should be compulsorily maintained*
- *Suggestion box should be kept at PHCs*
- *VHSC should meet regularly and record the proceedings*
- *Health survey, house hold survey, MCH survey, should be part of VHSC records*
- *GP and VHSC members along with MO and medical staff should under go a joint sensitization training programme.*
- *Mutual trust process should be evolved.*

## **SECTION VII**

### **SUMMARY AND CONCLUSIONS**

Conclusions and recommendations appear under individual sections. However when we further analyze, they can be brought under three main categories namely, Monitoring, Governance and Institution development.

#### **Monitoring**

ZP, TP and GP have an important role of monitoring of health activities falling under their geographical jurisdictions. The Roles and Responsibilities are well defined through Activity mapping; however in actual practice the situation is different. The study shows that the PRIs have not been able to effectively monitor the health activities as well as the performance of the health staff. The reasons are many:

Perceived lack of well defined Roles:

- Functions of the health officials have been listed in schedule 1, 2 &3 of the KPA 1993. They have been further reformed and under an amendment to the KPA in 2003, detailed activity mapping has been done. Health officials informed during field visits that they are no written down roles and responsibilities for them to perform. They are functioning mainly as per the directions of the Health Commissioner and the government.
- Health officials are also responsible in implementing national and state programmes.
- There are already certain provisions under the KPRA for the elected representatives to exercise. PRIs and their standing committees are not aware of their roles and responsibilities. They have not discharged effectively their roles utilizing these provisions.
- They have provisions under standing committee to commission studies and conduct surveys to monitor the programmes as well as performance of functionaries. They have not conducted regular visits to health centers. Visits made occasionally are only an exception.

Lack of proper Monitoring

- ZP Presidents have not obtained regular reports from the institutions under them and from the field.
- GP Presidents have to monitor the functioning of Amenities Committees and Anganwadi workers. They have not discharged this role.
- Annual plans and budgets are not reviewed with reference to the performance of health officials.

- Important parameters like, availability or non-availability and absenteeism of doctors and health are not discussed regularly in Standing Committees. Equally important parameters namely drug stock outs, increase/decrease in the number of patients visiting the health centers should also be included in the agenda of Standing Committees for discussions.
- Mutually agreed Annual targets and goal posts are not fixed for health functionaries.
- Presidents of ZP, TP, GP and chairpersons of Standing Committees at present are not competent enough to review and monitor health functionaries.
- Elected representatives consider non financial activities not as important as they do not get visibility; whereas creation of infrastructure does.

Attitudes of the functionaries that affect performance:

- Most of the health functionaries consider health as a 'technical' subject and PRIs are not competent enough to understand health issues.
- Health functionaries do not welcome the idea of PRIs monitoring their performance. They prefer to work directly under the Health & Family welfare department.
- Mistrust & ego are playing major role.

### **Governance and Institution development**

Good Governance and effective performance of institutions are the hallmarks of a decentralized system. Equally important issues are transparency accountability and access to information. Our study has shown that under the existing system both PRIs and institutions created for good governance are not functioning effectively. Thus they have affected monitoring health outcomes and quality of health services.

The issues listed below highlight the need for a review of the institutions:

- Standing Committees are not provided enough information which otherwise could have improved the quality of discussion. Construction of buildings, purchase of equipment is the main agenda for discussion. There appears to be no continuity in discussions.
- Various steps and processes adopted by health officials at times look routine and lack insight.
- There is a lack of proper coordination between PRIs and health functionaries. PRIs have difficulty in accessing information. Health officials do not provide timely information to the ZP, TP, GP and even VHSC. This has to a large extent handicapped the PRIs in effectively monitoring and improving the quality of health services. They have not demanded information from health officials.



- PRIs do not keep proper documentation of proceedings, plans, budgets, surveys, and monitoring and field visits.
- Institutions like VHSC, ARS and RKS, which are claimed to be the pillars of community, based monitoring and active involvement of GPs/TPs under NRHM have not functioned effectively.
- VHSCs are still not considered as sub committee of GP. This has undermined the role and importance of GPs.
- Let alone GPs even VHSCs are not privy to the health information.
- Health surveys are conducted by ANMs and ASHAs, but health information registers are not kept at VHSCs.
- There is a lack of coordination between PHC and VHSC.
- Monthly meetings of VHSCs are not held
- Health information boards are not displayed at important places in villages.
- Public dialogues are not conducted. Their reports not available with GPs and VHSCs
- GP presidents do not supervise SCs and Anganwadis. ANMs do not submit fortnightly reports to VHSCs.
- ANM and SC staff does not work under the supervision of VHSC/GP.They work under the direct control and supervision of MOs.
- GP Presidents and VHSCs have broadly understood issues that are discussed in VHSCs.
- RKS and ARS do not function as independent hospital and health management institutions; they do not function like independent NGOs. They are an extension to the health department. They do not prepare plan for spending untied funds.
- Local resource mobilization is not done.
- Jansunvais are not held. This has defeated the community-monitoring goal of NRHM.
- Drug stock outs and out of pocket expenses have affected the quality of services.
- Aggrieved patients do not complain. Patients do not bring their grievances to the elected representatives. Rather they approach local leaders.

Due to lack of transparency and accountability, restrictions in flow of information, institutional failures have occurred. This has affected the monitoring of health activities and related health functionaries. Quality of health services could have been better if some of these shortcomings were overcome.

## **SECTION - VIII**

### **RECOMMENDATIONS**

In order to bring effective monitoring of health activities and health functionaries by the PRIs there by improving the quality of health services, the following recommendations are made.

#### **Capacity Building**

- First and foremost sensitization and capacity building training programmes should be conducted for the elected representatives and health officials. This programme should focus on minimizing the trust deficit; improve coordination between the two sets of authorities.

#### **Training Programs**

- Training programmes should also be conducted for the ZP, TP and GP elected representatives to make them aware of the existing opportunities for reviewing the monitoring health activities and health functionaries.
- Proper capacity building programmes have to be conducted for ARS/RKS/VHSC members in respect of conducting meeting, budgeting, accounting and management.

#### **Information Systems**

- In order to improve the monitoring capacity of Standing Committees, proper information flow (MIS) should be established among the three tiers, preferably independent of health department system.
- Evaluation studies and survey related should be conducted by Standing Committees; its members should visit the health centers frequently and interact with the community.
- A Health information register could be a good basis for the MO to estimate the demand for drugs and disease mapping.

#### **Performance review system**

- Wider consultations with health fraternity, legal and PRI experts have to be held before drafting a detailed performance review system. An expert committee should be constituted.
- To start with elected representatives should be given the responsibility of writing their review on the performance of health functionaries working under their geographical jurisdiction. But they should do so after full consultations with DHO and CEO.

- Ultimate authority should be with DHO and Health Commissioner. However, they should mandatorily consider the reviews of elected representatives.
- Enough opportunities should be given for the health officials to contest these reviews.

### **Strengthen Jansunvais**

- Jansunvais should be used as a community audit to review the performance of health functionaries. Jansunvais should be mandatorily conducted by GPs with the help of independent well meaning publicly acclaimed persons. The outcome of this social audit should be the basis to review the performance of health officials at village level and the quality of health services.

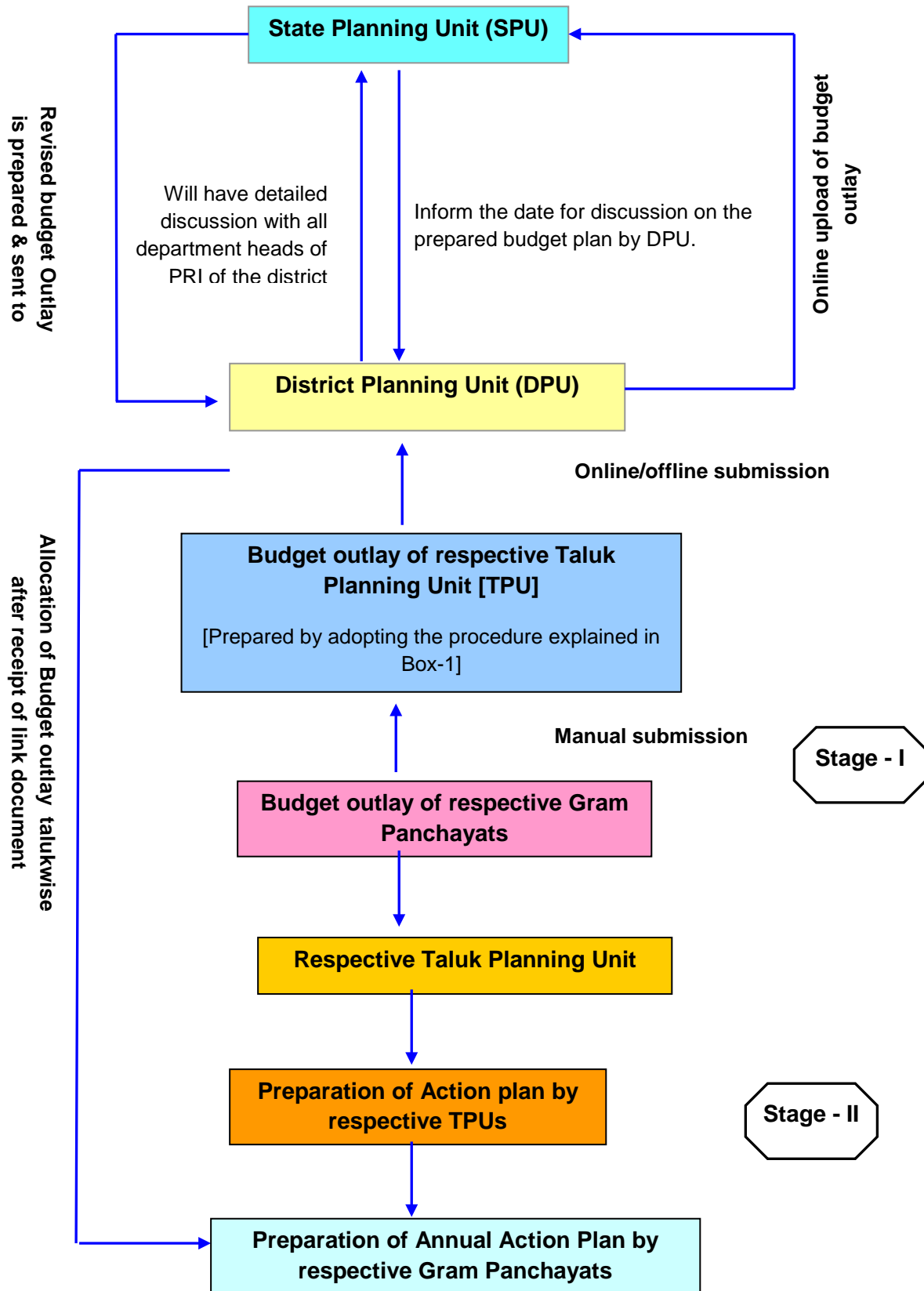
### **Structural recommendation**

- To start with on a pilot basis, in selected GPs, salaries of ANMs and SC staff should be deposited with GPs and salaries of MOs and PHC staff should be deposited with TPs and their salaries can be released after TPs and GPs in consultation with the community reviewing their performance. These institutions should be provided with proper escort service.

# **ANNEXURES**

ANNEXURE 1

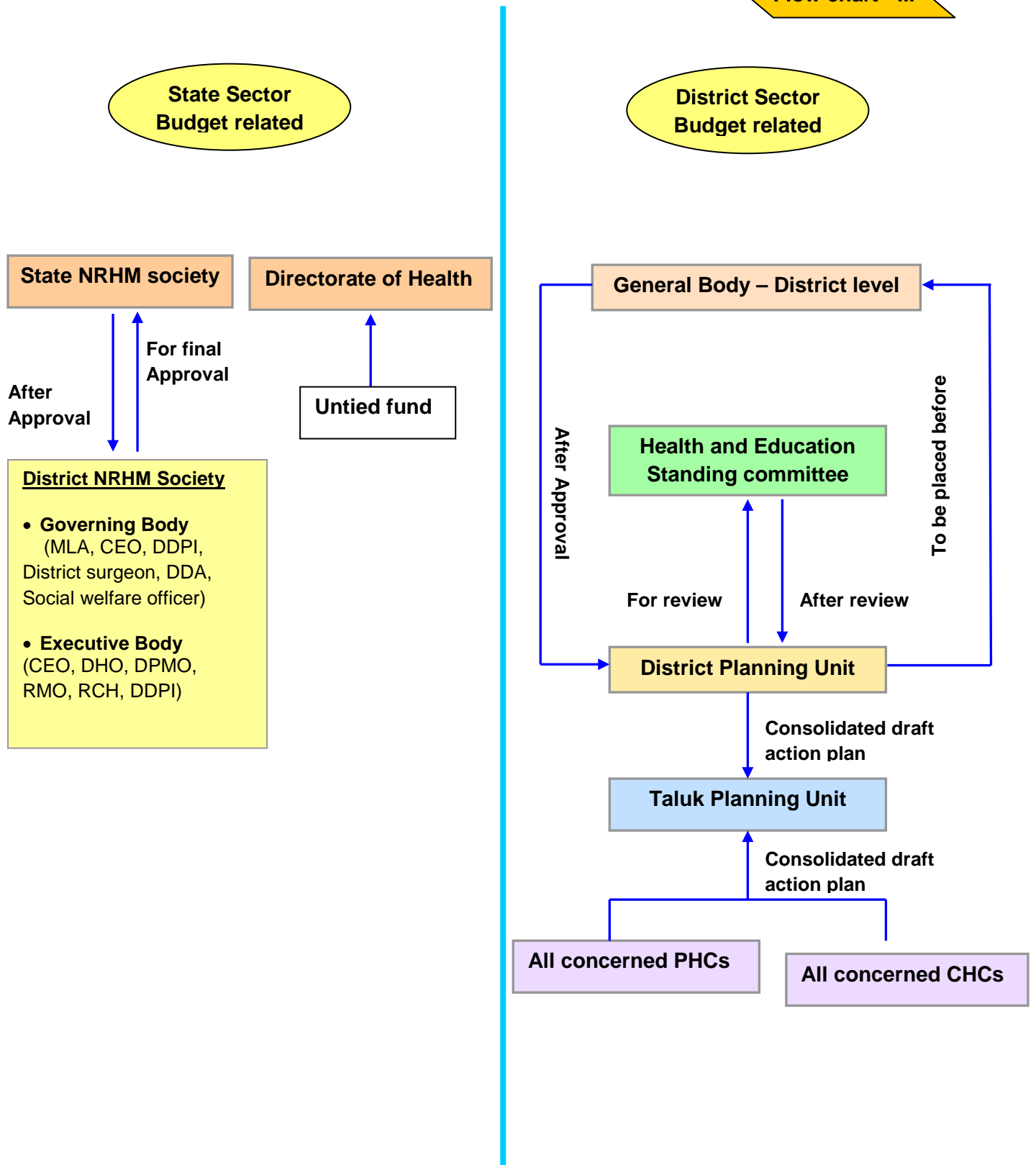
FLOW CHART II STATE PLANNING PROCESS



**ANNEXURE 2**

**DECISION MAKING PROCESS - HEALTH:**

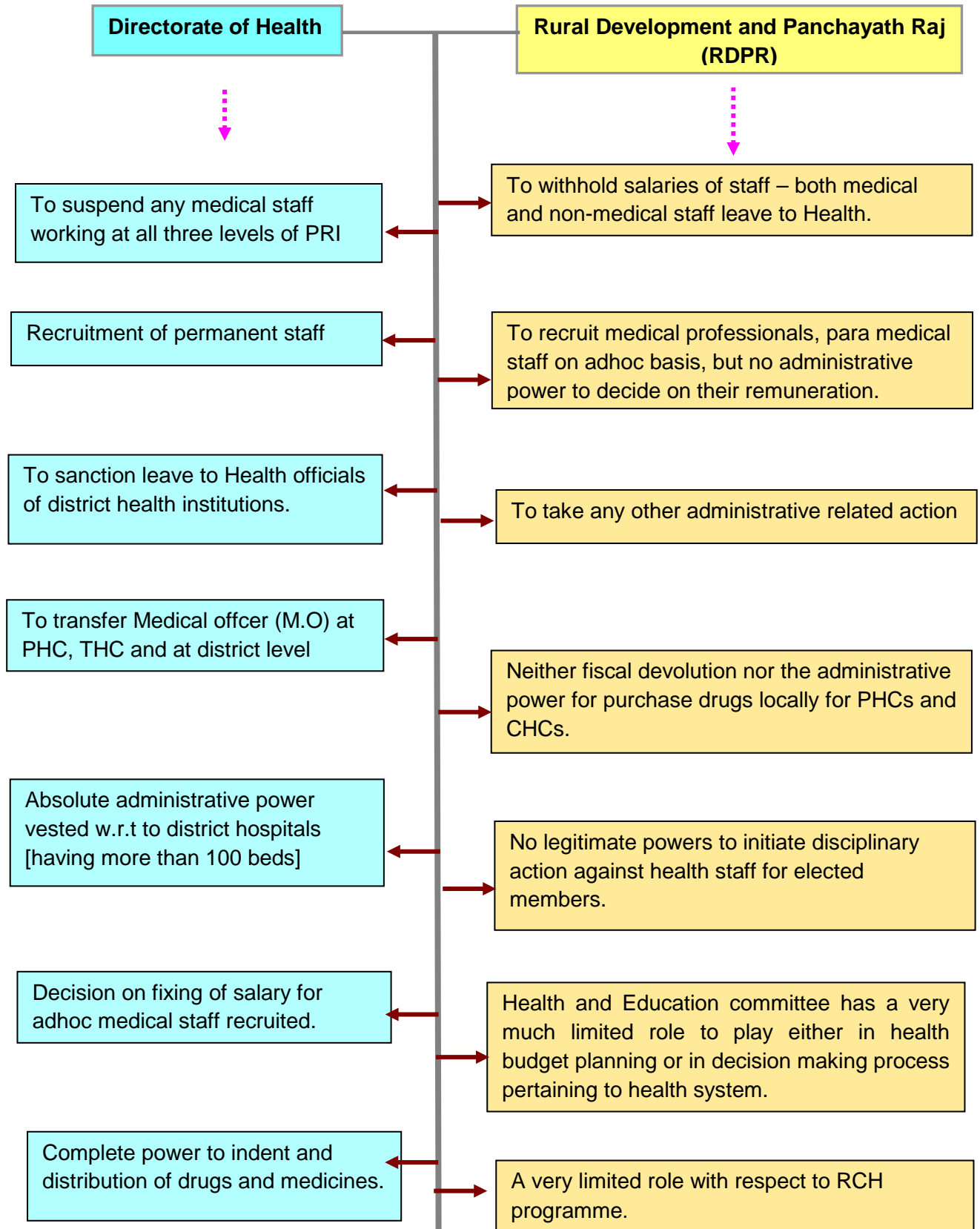
**Flow chart - III**



ANNEXURE 3

Flow chart - IV

Functional powers of State and PRI pertaining to Health system:



## Annexure 4

### Medical Officer- THO

**Taluk:**

**Name of the**

**Taluk Hospital :**

**Name of the Centrally sponsored Scheme (CSS)-**

I. Socio economic Details

- (i) Name of the MO:
- (ii) Age:
- (iii) Gender:
- (iv) Educational Qualification:
- (v) Length of service:
- (vi) Number of years in present institution:

II. Health Planning at PHC level

Who are involved in the various planning process?

- (i) ZP/ TP members/president
- (ii) DHO
- (iii) ZP members
- (iv) VHC/VHSC
- (v) Any other---

With whom the various plans are discussed?

- a) DHO
- b) ZP/TP
- c) Standing committee members
- d) Others---



Role of standing committee in health planning, monitoring etc?

- (i) How many times the standing committee met in last year?
- (ii) What are the health related subjects being covered?
- (iii) Your opinion on TP/standing committee's participation in health planning?

### III. Review / & Monitoring

What are the roles performed by following bodies in reviewing health plan execution ?

- (a) TP general body
- (b) Standing committee ( General Standing Committee;/ Finance, Audit and Planning Committee/Social Justice Committee

Who reviews the performance of Taluk/GP level health staff?

Who does the following action for MO and other staff at Taluk Health Hospital?

- (a) Sanction leave?
- (b) Write CRs?
- (c) Take disciplinary action?

## ANNEXURE: 5

### District Health Officer

#### DISTRICT:

#### I. Socio economic Details

- a) Name of the DHO:
- b) Age:
- c) Gender
- d) Educational Qualification:
- e) Length of service:
- f) Number of years in present position:

#### II. Health Planning at District level

What are the types of planning Process that take place at PHC ?

- (a) Disease mapping
- (b) Drugs planning
- (c) Staff planning
- (d) Extension and education plan
- (e) Infrastructure planning
- (f) Utility planning
- (g) Others----

Who are involved in the various planning process?

- (a) ZP Members/President
- (b) DHO
- (c) Standing committee members
- (d)Others-(specify)

With whom District plans are discussed?

ZP President /CEO/Standing Committee members/Health  
Commissioner

Who approves District health plan?

ZP President /CEO/Standing Committee members/Health  
Commissioner

III. Review / & Monitoring

(i) Who reviews and monitors the performance of District Health level health staff?

ZP President/DHO/ DC/Commissioner

(ii) Who is sanctioning leave/Write CRs/Take disciplinary actions of district level health Staff?

ZP President/DHO/ DC/Commissioner

(iii) Who reviews and monitors your performance?

ZP/Commissioner

(iv) Who is sanctioning your leave/Write CRs/Take disciplinary actions ?

ZP /Commissioner

IV. Opinion on PRI

(a) Your views on providing statutory powers to the PRI in over all planning/monitoring/reviewing health delivery system

a. No power should be given to PRI

b. Delink Health activity from PRI

c. Giving more powers to PRI

d. Continue with existing system

(b) Instances of positive/negative experiences due to PRI's involvement?

Delay in Salary/ delay in funds for programmes /others Explain

## ANNEXURE : 6

### NRHM Society

#### District:

#### I. Socio economic Details

- (i) Name of the Member/Manager:
- (ii) Age:
- (iii) Gender
- (iv) Educational Qualification:
- (v) Length of service:
- (vi) Number of years in present current position:

#### II. Health Planning of NRHM at District level

What are the types of planning Process that take place at NRHM ?

- (i) Disease mapping
- (ii) Drugs planning
- (iii) Staff planning
- (iv) Extension and education plan
- (v) Infrastructure planning
- (vi) Utility planning
- (vii) Others----

What are the various committee formed at different level?

- (a) VHSC
- (b) PHC planning and monitoring committee
- (c) Taluk planning and monitoring committee
- (d) District planning and monitoring committee
- (e) Any other

Who are involved in each of the above committee? How they are different from the regular village Health committee at village level and standing committee at Taluk /District level of PRI?

What are the various planning taking place at different levels?

What are the funds handled by these committees?

What are the roles of PRIs in each of the above programme?

Who approves the various health plans?

### III. Review / & Monitoring

Who reviews and monitors the performance of health staff at different level?

- (i) Sub centre
- (ii) PHC
- (iii) CHC
- (iv) Taluk Hospital
- (v) District Hospital
- (vi) NRHM Society
- (vii) PRI

### IV. Opinion on PRI

Your views on providing statutory powers to the PRI in over all planning/monitoring/reviewing health delivery system

- (i) No power should be given to PRI
- (ii) Delink Health activity from PRI
- (iii) Giving more powers to PRI
- (iv) Continue with existing system

## ANNEXURE : 7

### RCH

**Taluk:**

**Name of the Taluk Hospital :**

#### I. Socio economic Details

- (i) Name of the MO:
- (ii) Age:
- (iii) Gender
- (iv) Educational Qualification:
- (v) Length of service:
- (vi) Number of years in present institution:

#### RCH Planning at PHC level

What are the types of planning Process that take place at Taluk Place under your jurisdiction?

- (i) Disease mapping
- (ii) Drugs planning
- (iii) Staff planning
- (iv) Extension and education plan
- (v) Infrastructure planning
- (vi) Utility planning
- (vii) Others----

Who are involved in the various planning process?

- (a) TP members/president
- (b) DHO
- (c) ZP members
- (d) VHC/VHSC
- (e) Any other---

With whom the various plans are discussed?

- (i) DHO
- (ii) ZP/TP
- (iii) Standing committee members
- (iv) Others---

Role of standing committee in health planning, monitoring etc?

- (i) How many times the standing committee met in last year?
- (ii) What are the health related subjects being covered?
- (iii) Your opinion on TP/standing committee's participation in health planning?

## II. Review / & Monitoring

What are the roles performed by following bodies in reviewing health plan execution ?

- (i) TP general body
- (ii) Standing committee ( General Standing Committee;/ Finance, Audit and Planning Committee/Social Justice Committee

Who reviews the performance of Taluk/GP level health staff?

Who does the following action for MO and other staff at Taluk Health Hospital?

- (i) Sanction leave?
- (ii) Write CRs?
- (iii) Take disciplinary action?

## ANNEXURE: 8

### Chief Accounts Officer

#### District:

#### I. Socio economic Details

- (i) Name of the CAO:
- (ii) Age:
- (iii) Gender
- (iv) Educational Qualification:
- (v) Length of service:
- (vi) Number of years in present position:

#### II. Health Planning at TP/ZP level

Who are involved in the financial planning and budgeting with respect to health?

- (i) ZP members/ZP president
- (ii) General Body
- (iii) Health and Education standing committee
- (iv) Any other---

With whom the various plans are discussed?

- (i) DHO
- (ii) ZP/TP
- (iii) Standing committee members
- (iv) DC
- (v) Others

Explain the procedure of health expenditure at ZP level--

Are you responsible for release of salary to Health Department officials?

Are you responsible for release of funds to other expenses like construction, purchase of drugs etc?



Who has to authorize expenses?

- (a) CEO
- (b) Standing Committee
- (c) DHO

What is the role of Health Department in Budget and expenditure ?

### III. Auditing

- (i) Are you responsible for auditing of ZP accounts?
- (ii) How audits are being done- through State accounts OR CAG ?
- (iii) How often audits are being done?
- (iv) What actions are taken on the audit observations ?

### IV. Your suggestions to improve Budget/Receipt/Expenditure System at ZP

## ANNEXURE: 9

### Chief Executive Officer

#### District:

#### I. Socio economic Details

- (i) Name of the CEO:
- (ii) Age:
- (iii) Gender:
- (iv) Educational Qualification:
- (v) Length of service:
- (vi) Number of years in present position:

#### II. Health Planning at TP/ZP level

Who are involved in the financial planning and budgeting with respect to health?

- (i) ZP members/ZP president
- (ii) General Body
- (iii) Health and Education standing committee
- (iv) Any other---

With whom the various plans are discussed?

- (i) DHO
- (ii) ZP/TP
- (iii) Standing committee members
- (iv) DC
- (v) Others

Explain the procedure of health expenditure at ZP level—

- (i) Role of ZP standing committee in Health Budget Preparation
- (ii) Money transfers from the state government regarding timeliness and sufficiency
- (iii) Is ZP accounts annually audited (State accounts/CAG)?

- (iv) Are audit observations being discussed in general body meeting and acted upon the observations?
- (v) Are you responsible for release of salary to Health Department officials?
- (vi) Are you responsible for release of funds to other expenses like construction, purchase of drugs etc?
- (vii) Who has to authorize expenses?
  - (a)CEO      (b) Standing Committee      (c) DHO
- (viii) What is the role of Health Department in Budget and expenditure?
- (ix) Can you reject the resolution of ZP General meetings / Standing committee meetings
- (x) Can you recommend your views to the government for actions at the time of disagreements?
- (xi) Can you take disciplinary action against health staff?
- (xii) Do health staff report to you OR to their respective department heads?
- (xiii) Do you write the CRs of ZP health officials

III. Your suggestions/opinion to improve quality of services-

- (a) Current powers of ZP are not enough
- (b) Give more powers/freedom to ZP
- (c) Restrict the role of ZP
- (d) Any other

## ANNEXURE: 10

### Chief Planning Officer

#### District:

#### I. Socio economic Details

- (i) Name of the CAO:
- (ii) Age:
- (iii) Gender
- (iv) Educational Qualification:
- (v) Length of service:
- (vi) Number of years in present position:

#### II. Health Planning at TP/ZP level

Who are involved in the financial planning and budgeting with respect to health?

- (i) ZP members/ZP president
- (ii) DHO
- (iii) VHC/VHSC
- (iv) Any other---

With whom the various plans are discussed?

- (i) DHO
- (ii) ZP/TP
- (iii) Standing committee members
- (iv) Others

- #### III
- (i) Explain the procedure of health expenditure at ZP level--
  - (ii) Do you regularly attend the standing committee meeting at taluk/District level?
  - (iii) What are the roles performed by following bodies in health planning?

(A) ZP general body      (B) Standing Committee

- IV      What is your role in preparation of ZP plan?
- (a) Aggregating GP/TP plans
  - (b) Consultations & placing before the general body / standing committee
  - (c) Preparation of link document
- V      Who is responsible to approve the plan?
- (a) ZP President
  - (b) CEO
  - (c) DC
  - (d) Planning secretary
- VI      Your opinion on ZP standing committee's participation in health planning
- VII .   Auditing
- a. Are you responsible for auditing of ZP accounts?
  - b. How audits are being done- through State accounts OR CAG ?
  - c. How often audits are being done?
  - d. What actions are taken on the audit observations ?
- VIII    Your suggestions to improve Budget/Receipt/Expenditure System at ZP

## ANNEXURE: 11

### Zilla Panchayat President

#### District:

- I. Socio economic Details
  - a. Name of the ZP president
  - b. AGE:
  - c. Gender
  - d. Caste:
  - e. Education:
  - f. Number of times elected for ZP:
  
- II. Planning at District level
  - (i) What are the various standing committees formed at ZP level?
  - (ii) Are you a member of standing committee?
  - (iii) How many various committees met during the last one year?
  - (iv) What are the issues discussed?
  - (v) Has DPC been constituted in your district?
  - (vi) If yes, how many times DPC has met in last one year?
  - (vii) What are the issues discussed? Please provide the minutes of the meeting
  - (viii) Are you satisfied with the functioning of DPC? Explain

## ANNEXURE: 12

### EDUCATION & HEALTH STANDING COMMITTEE MEMBER

#### DISTRICT:

- (i) Name of the ZP president
- (ii) Age:
- (iii) Gender
- (iv) Caste:
- (v) Education:
- (vi) Number of times elected for ZP:
- (vii) Total number of members in Finance standing committee:

#### PLANNING AT DISTRICT LEVEL

- (i) How many times the health and Education Standing Committee met during the last one year?
- (ii) What are the important health programmes evaluated/discussed under this standing committee?
- (iii) What functions were performed by the committee with respect to
  - a. Health services
  - b. Hospitals
  - c. Family welfare and allied activities
- (iv) How many times review was conducted by the committee in evaluating planned programmes?
- (v) What role you have performed with respect to health planning, budget allocation in the district?
- (vi) Does committee sanction any funds?
- (vii) Various funds sanctioned/recommend during last one year?
- (viii) Does this Standing committee have a role in reviewing the performance of the ZP level health staff?

III Review / & Monitoring

- (i) What are the roles performed by following bodies in reviewing health plan execution and monitoring?
  - (c) ZP general body
  - (d) Standing committees
  - (e) Others
- (ii) What are the actions initiated based on review?
- (iii) Do you
  - a. Sanction leave?
  - b. Write CRs?
  - c. Take/ recommend Health Officer disciplinary action?



## ANNEXURE: 13

### Centrally Sponsored Scheme

**District:  
Scheme:**

**Name of the CS**

I. Socio economic Details

- (i) Name of the officer in charge of District Unit:
- (ii) Age:
- (iii) Gender
- (iv) Educational Qualification:
- (v) Length of service:
- (vi) Number of years in present RCH :

II. Health Planning at District level

(i) What are the types of planning Process that take place at district level with respect to this scheme?

- i. Disease mapping
- ii. Drugs planning
- iii. Staff planning
- iv. Extension and education plan
- v. MDG Plan
- vi. Infrastructure planning
- vii. Utility planning
- viii. Others----

(ii) Who approves the plan at district level?

Zilla Panchayat Standing Committee / DC / DHO/JD in charge of scheme

(iii) What are the mechanisms to identify the persons with positives at different levels?

Sub centers/PHCs/CHC/TH

(iv) How many new patients come every month from different institutions?

(v) Does your district Unit have sufficient infrastructure for catering to both existing and new patients?

(a) pathology laboratory

(b) X-ray machine

(c) Drugs

III Review / & Monitoring

Who reviews and monitors the implementation of centrally sponsored schemes?

(a) Standing Committee

(b) TP/ZP Presidents or members

(c) DHO

(d) JD in charge of scheme

Who reviews and monitors the performance of CSS staff?

(f) TP general body / ZP /EO

(g)DHO

(h)JD in charge of the scheme

(i) Others (specify)

Who is sanctioning leave/Write CRs/Take disciplinary actions of CSS staff ?

(a) ZP General Body /ZP President

(b) DHO

(c) CEO

(d) JD in charge of the scheme

IV Opinion on effective functioning of CHCs

Your views on providing statutory powers to the PRI in over all planning/monitoring/reviewing health delivery system of centrally sponsored scheme

- a. No power should be given to PRI
- b. Delink Health activity from PRI
- c. Giving more powers to PRI
- d. Continue with existing system

What comes as a constraint in effective functioning ?

- (a) Infrastructure like (i)mobility (ii) Drugs (iii) laboratory facility
- (b) Specialists
- (c) Paramedical staff
- (d) Interventions by elected representatives of PRI
- (e) Legislature
- (f) Politicians
- (g) Local leaders
- (h) Others

**ANNEXURE: 14**

**Medical Officer- CHC**

<b>Taluk:</b>	<b>Name of the CHC:</b>	<b>No. of PHCs come</b>
<b>under PHC:</b>		

I. Socio economic Details

- i. Name of the MO:
- ii. Age:
- iii. Gender
- iv. Educational Qualification:
- v. Length of service:
- vi. Number of years in present CHC:

II. Health Planning at CHC level

1. What are the types of planning Process that take place at CHC ?

- i. Disease mapping /Drugs planning/Staff planning/Extension and education plan/
- ii. Infrastructure planning /Utility planning/Others----

2. Who approves CHC health plan?

- a. TP/THO/DHO/ZP/----

How many specialists are filled up in this CHC? Mention the types (Medicines/Surgery/Pediatrics/Gynaecology)

3. How many are outsourced?

4. What are the mechanisms to have the referrals from PHCs?

5. How many referrals come every month from different PHCs coming under this CHC?

6. Does your CHC have sufficient infrastructure for catering to referrals ?

(a) operation theatre

(b) labour room

(c) pathology laboratory

(d) X-ray machine

(e) Refrigerator

(f) Generator

III Review / & Monitoring

(i) Who reviews and monitors the infrastructure(s) and maintenance of the CHC?

(a) Standing Committee

(b) TP/ZP Presidents or members

(c) DHO

(ii) Who reviews and monitors the performance of CHC staff?

1. TP general body / ZP /EO

2. DHO

3. Others (specify)

(iii) Who is sanctioning leave/Write CRs/Take disciplinary actions of CHC staff?

TP General Body/TP President/ZP President

DHO / EO/CEO

(iv) Who reviews and monitors your performance?

TP/ZP /EO/CEO

(v) Who is sanctioning your leave/Write CRs/Take disciplinary actions?

a. TP president/ZP President

b. DHO/Director /Commissioner

c. EO/CEO

IV Opinion on effective functioning of CHCs

(A) Your views on providing statutory powers to the PRI in over all planning/monitoring/reviewing health delivery system at CHC level

- i. No power should be given to PRI
- ii. Delink Health activity from PRI
- iii. Giving more powers to PRI
- iv. Continue with existing system

(B) What comes as a constraint in effective functioning?

- a. Infrastructure
- b. Specialists
- c. Paramedical staff
- d. Interventions by elected representatives of PRI
- e. Legislature
- f. Politicians
- g. Local leaders
- h. Others

**ANNEXURE: 15**

**Executive Officer**

**Taluk:**

**District:**

I. Socio economic Details

- (i) Name of the EO:
- (ii) Age:
- (iii) Gender
- (iv) Educational Qualification:
- (v) Length of service:
- (vi) Number of years in present Taluk :

II. Health Planning at Taluk level

1. What are your functions with respect to Taluk level health plan?
2. What is your role in
  - a. Setting guidelines for village level health planning?
  - b. Reviewing the plan submitted by PHC?
  - c. Reviewing the health plans submitted by CHC/ Taluk hospital?
3. Whom do you send taluk health plans for discussion?

TP/ZP/DHO/Standing committee of TP
4. Who will approve the taluk Health Plan?
  - i. TP/ZP/DHO/Standing committee of TP

III Review / & Monitoring

I. Who reviews and monitors the performance of taluk level health staff?

- i. TP general body
- ii. TP President/ZP President/Taluk level Standing committee/  
THO/DHO/CEO

II. Who is sanctioning leave/Write CRs/Take disciplinary actions of staff at Taluk level?

- i. TP General Body/TP President
- ii. TP standing committee/THO/DHO/--
- iii.

III. Who reviews and monitors your performance?

1. TP general body/TP President/ZP President
2. TP standing committee

IV. Who is sanctioning your leave/Write CRs/Take disciplinary actions?

- (a) TP general body/TP President/ZP President /CEO/DC
- (b) DHO/Director /Commissioner

IV Opinion on PRI

Your views on providing statutory powers to the PRI in over all planning/monitoring/reviewing health delivery system at PHC level

1. No power should be given to PRI
2. Delink Health activity from PRI
3. Giving more powers to PRI
4. Continue with existing system

Instances of positive/negative experiences due to PRI's involvement?

Delay in Salary/ delay in funds for programmes /others. Explain





III. Review / & Monitoring

- a) Is there a Quality Assurance Committee (QAC) formed in the district ?
- b) Is QAC Functional?
- c) Who are the members of the District QAC?
- d) How many times the district QAC has met during the last one year?
- e) What are existing recording mechanisms?
- f) Who reviews and monitors the infrastructure(s) and maintenance of the CHC?
  - a. Standing Committee (b) TP/ZP Presidents or members (c) DHO
- g) Who reviews and monitors the performance of CHC staff?
  - a. TP general body / ZP /EO
  - b. DHO
  - c. Others (specify)
- h) Who is sanctioning leave/Write CRs/Take disciplinary actions of CHC staff?
  - a. TP General Body/TP President/ZP President
  - b. DHO
  - c. EO/CEO
- i) Who reviews and monitors your performance?
  - a. TP/ZP
  - b. DHO /EO/CEO
- j) Who is sanctioning your leave/Write CRs/Take disciplinary actions?
  - a. TP president/ZP President
  - b. DHO/Director /Commissioner
- k) EO/ Opinion on effective functioning of CHCs
- l) Your views on providing statutory powers to the PRI in over all planning/monitoring/reviewing health delivery system at CHC level

- a) No power should be given to PRI
  - b) Delink Health activity from PRI
  - c) Giving more powers to PRI
  - d) Continue with existing system
- m) What comes as a constraint in effective functioning?
- a) Infrastructure Specialists
  - b) Paramedical staff
  - c) Interventions by elected representatives of PRI
  - d) Politicians /Local leaders
  - e) Others
  - f) CEO

## ANNEXURE: 17

### ROGI KALYAN SAMITHI MEMBER

**Village:**  
**District:**

**PHC:**

**Taluk:**

#### I. Socio economic Details

- a. Name of RKS member:
- b. Age:
- c. Gender
- d. Caste:
- e. Education:
- f. Total number of members in RKS members:
- g. When it was formed:

#### II. Planning at Taluk level

- a. When was RKS formed? How many times it has met during the last one year?
- b. What are the issues discussed in the meeting?
- c. What role do you play in improving the health services in your area?
- d. What funds do you handle and how they are being utilized?
- e. What are the issues being discussed in the committee meeting?
- f. How do you monitor the health services and do you monitor any village level health staff?
- g. Are you aware of any resource mobilization under RKS? As a member have you mobilized resources?
- h. What are your comments regarding your involvement as RKS member in handling health issues?

## ANNEXURE: 18

### Taluk Panchayat President

**Taluk:**

**District:**

I. Socio economic Details

- a. Name of the Taluk president
- b. Age:
- c. Gender
- d. Caste:
- e. Education:
- f. Number of times elected for GP:

II. Planning at Taluk level

- a. Are various standing committees (General Standing Committee;/ Finance, Audit and Planning Committee/Social Justice Committee) constituted?
- b. Are you and TP members part of standing committee?
- c. How many various committee met during the last one year?
- d. What are the issues discussed?
- e. Who is responsible for TP health planning? (THO/DHO/TP/---etc)
- f. What is your role in TP Health Planning?
- g. Does TP has a record of Taluk health plan?
- h. How do you use the TP health plan?
- i. Suggestions to improve TP health Planning?

III. Review / & Monitoring

What are the roles performed by following bodies in reviewing health plan execution and monitoring?

- i. TP general body
- ii. Standing committees
- iii. Others

Role of women TP members in immunization, polio eradication campaigns, local health camps, encourage women to access safe delivery, epidemic outbreaks—

- a. What are the actions initiated based on review?  
Impact of personal visit / review
- b. Who are the Block level/TP level Health staff? Do they report to you?
- c. Do you prepare health budget based on health plan?
- d. What are the budget items for health under TP?
- e. Do you receive funds for health issues?
- f. What are the sources of this fund? (Govt/Own/Others)
- g. Do you review the performance of TP level health staff?
- h. Do you monitor the attendance of the Taluk Hospital staff?
- i. Do you
  - i. Sanction leave?
  - ii. Write CRs?
  - iii. Take/ recommend Health Officer disciplinary action?
- j. What is the Taluk panchayat member's role in functioning of various standing committee?
- k. Do you have half yearly report regarding the activities of Gram Panchayats within the taluk? How do you use them?

## ANNEXURE: 19

### Taluk Health Officer /Taluk Medical Officer

**Taluk:**

**District:**

I. Socio economic Details

- a. Name of the THO/TMO:
- b. Age:
- c. Gender
- d. Educational Qualification:
- e. Length of service:
- f. Number of years in present Taluk Hospital :

II. Health Planning at Taluk level

- a. What are your functions with respect to Taluk level health plan?
- b. What is your role in
  - i. Setting guidelines for village level health planning?
  - ii. Reviewing the plan submitted by PHC?
  - iii. Reviewing the health plans submitted by CHC/ Taluk hospital?
- c. To whom do you send taluk health plan for discussion?
  - a. TP/ZP/DHO/Standing committee of TP
- d. Who will approve the taluk Health Plan?
  - a. TP/ZP/DHO/Standing committee of TP

III. Review / & Monitoring

Who reviews and monitors the performance of taluk level health staff?

- i. TP general body
- ii. TP President/ZP President/Taluk level Standing committee/ THO/DHO

Who is sanctioning leave/Write CRs/Take disciplinary actions of staff at Taluk level?

- i. TP General Body/TP President
- ii. TP standing committee/THO/DHO/--

Who reviews and monitors your performance?

- i. TP general body/TP President/ZP President
- ii. TP standing committee/DHO

Who is sanctioning your leave/Write CRs/Take disciplinary actions?

TP general body/TP President/ZP President

DHO/Director /Commissioner

#### IV Opinion on PRI

Your views on providing statutory powers to the PRI in over all planning/monitoring/reviewing health delivery system at PHC level

- i. No power should be given to PRI
- ii. Delink Health activity from PRI
- iii. Giving more powers to PRI
- iv. Continue with existing system

Instances of positive/negative experiences due to PRI's involvement?

Delay in Salary/ delay in funds for programmes /others . Explain



## ANNEXURE: 20

### Finance, Budget & Planning- Standing Committee Member-

#### I. Socio economic Details

- i. Name of the Taluk president
- ii. Age:
- iii. Gender
- iv. Caste:
- v. Education:
- vi. Number of times elected for GP:
- vii. Total number of members in Finance standing committee:

#### II. Planning at Taluk level

- i. Procedures involved in framing the budgets, proposal scrutiny and expenditure for receipts and expenditure?
- ii. Are various standing committees (General Standing Committee/ Finance, Audit and Planning Committee/Social Justice Committee) constituted?
- iii. How long you have been a member of Finance standing committee?
- iv. How many times Finance committee met during the last one year?
- v. What are the issues discussed?
- vi. What role you have performed with respect to health planning, budget allocation in the taluk?
- vii. Does committee sanction any funds? Various funds sanctioned/recommend during last one year?
- viii. Does Finance Standing committee has a role in reviewing the performance of the TP level health staff?

#### III. Review & Monitoring-

What are your comments regarding your involvement as Finance Standing Committee member in handling health issues?

## ANNEXURE: 21

### Gram Panchayat President

**GP Name:**

**Taluk:**

**District:**

#### I. Socio economic Details

- i. Name of the GP president
- ii. Age:
- iii. Gender
- iv. Caste:
- v. Education:
- vi. Number of times elected for GP:

#### II. Planning at GP level

- i. Is VHSC/VHC Constituted?
- ii. How many times it has met during the last one year?
- iii. What are the issues discussed?
- iv. Who is responsible for GP health planning? (GP/PHC/---)
- v. What is your role in Village Health Planning?
- vi. Does GP have a record of GP/village health plan?
- vii. How do you use the GP health plan?
- viii. Suggestions to improve GP health Planning?

#### III. Review / & Monitoring

- i. What are the roles performed by following bodies in reviewing health plan execution?
  1. GP general body
  2. VHSC/VHC
- ii. Role of VHSC in selection of ASHA---

- iii. Role of women GP members in immunization, polio eradication campaigns, local health camps, encourage women to access safe delivery.
- iv. What are the actions initiated based on review?
- v. Impact of personal visit / review
- vi. Who are at the village level/GP level Health staff? Do they report to you?
- vii. Do you prepare health budget based on health plan?
- viii. What are the budget items for health?
- ix. How do you operate health fund?
- x. What are the sources of health fund? ( Govt. /Own/Others)
- xi. Do you review the performance of village/GP level health staff?
- xii. Do you monitor the attendance of the PHC / Sub centre staff?
- xiii. Do you
  - i. Sanction leave?
  - ii. Write CRs?
  - iii. Take/ recommend Health Officer disciplinary action?
- xiv. What is panchayat member's role in selection of ASHA?
- xv. What barriers you experience in executing your powers?
  - i. Knowledge
  - ii. Training
  - iii. Complete information about roles and responsibilities
  - iv. Cooperation from the government officials
  - v. Any other

**ANNEXURE: 22**

**Medical Officer- PHC**

**Taluk:** \_\_\_\_\_ **Name of the PHC:** \_\_\_\_\_ **GPs come**  
**under PHC:** \_\_\_\_\_

I. Socio economic Details

- i. Name of the MO:
- ii. AGE:
- iii. Gender
- iv. Educational Qualification:
- v. Length of service:
- vi. Number of years in present PHC:

II. Health Planning at PHC level

- i. What are the types of planning Process that take place at PHC ?
- ii. Disease mapping
- iii. Drugs planning
- iv. Staff planning
- v. Extension and education plan
- vi. Infrastructure planning
- vii. Utility planning
- viii. Others----
- ix. Who are involved in the various planning process?
  1. ANM
  2. ASHA
  3. GP members
  4. VHC/VHSC
  5. ARS members
  6. Community members
- x. Any other---
- xi. Records of the meeting
- xii. With whom the various plans are discussed?

1. DHO
2. ZP/TP
3. GP
4. Others---

xiii. Who approves PHC health plan?

xiv. GP/THO/DHO/ZP/----

### III. Review / & Monitoring

- i. Who reviews and monitors the performance of village/GP level health staff?
  1. GP general body
  2. VHSC/VHC/ARS/MO-PHC/THO/DHO
- ii. Who is sanctioning leave/Write CRs/Take disciplinary actions of staff at PHC level?
  1. GP General Body/GP President
  2. VHSC/ARS/MO-PHC/DHO/--
- iii. Who reviews and monitors your performance?
  1. GP general body/TP/ZP
  2. VHSC /THO/DHO
- iv. Who is sanctioning your leave/Write CRs/Take disciplinary actions?
  1. GP General Body/GP President/TP president/ZP President
  2. THO/DHO/Director /Commissioner

### IV. Opinion on PRI

- i. Your views on providing statutory powers to the PRI in over all planning/monitoring/reviewing health delivery system at PHC level
  1. No power should be given to PRI
  2. Delink Health activity from PRI
  3. Giving more powers to PRI
  4. Continue with existing system

**ANNEXURE: 23**

**Arogya Raksha Samithi Members**

**Name of the PHC:  
District:**

**Village:**

**Taluk:**

I. Socio economic Details

- i. Name of the ARS member
- ii. Age:
- iii. Gender
- iv. Caste:
- v. Education:

II. Planning at GP level

- i. When was ARS formed? How many times it has met during the last one year?
- ii. What are the issues discussed in the meeting?
- iii. What role do you play in improving the health services in your area?
- iv. What funds do you handle and how they are being utilized?
- v. What are the issues being discussed in the committee meeting?
- vi. How do you monitor the health services and do you monitor any village level health staff?
- vii. Are you aware of any resource mobilization under ARS? As a member have you mobilized resources?
- viii. Your role in selection of ASHA workers—Explain

**ANNEXURE: 24**

**Sub-center Staff**

**Sub Center :**                      **PHC Name:**                      **Taluk:**                      **District:**

I. Socio economic Details

- i. Name of the Staff member
- ii. Age:
- iii. Gender
- iv. Education:
- v. Designation:
- vi. Total length of services (in years)
- vii. Number of years of service in this sub center:

II. Planning at sub center level

- i. Are you a member of VHSC?
- ii. What planning is done at VHSC?
- iii. How are you involved in following health planning process?
- iv. Disease mapping
- v. Drug planning
- vi. Extension and education planning
- vii. What funds are being handled in last 2 years? How?
- viii. To whom do you report the fund utilization?  
MO/ZP President/TP President/GP President

III. Review & Monitoring

- i. Who reviews your work?  
(a) GP Member      (b) Medical Officer      (c) Both
- ii. How many times it has been reviewed during last one year?  
(a) GP Member      (b) Medical Officer
- iii. What is your view about member's involvement in village health issue?

**ANNEXURE: 25**

**OUT Patient at PHC**

**Name of the PHC/CHC :**  
**District:**

**Taluk:**

I. Socio economic Details

1. Name of the OP:
2. Village/Town name:
3. Age:
4. Gender
5. Caste :
6. Education:
7. Occupation :
8. OPD slip number :

II. Details on

- i. Do you belong to the same village?
- ii. Reasons for visiting the PHC
  - a) Near to home
  - b) Good service
  - c) Minor ailment
  - d) For first aid treatment
  - e) It is free/ less costly
  - f) Recommended by others
  - g) Can't afford to go to private hospital
  - h) Any other reasons



iii. Did you / your family members visited this institution regularly?

i. If YES, Why?

ii. IF 'NO', Why?

iv. Whether the medicine prescribed were given in the hospital or purchased outside?

1. Given in the hospital

2. Purchased from outside

3. Partly given in the hospital and partly purchased from outside

v. Amount spent for purchasing medicine

vi. Was OPD charges collected? If yes, how much?

III Patient Satisfaction Level in the OPD

Please rate the following-

What is your opinion about the following in the waiting area

Sl.No		Excellent	Good	Bad
1	OPD space			
2	Seating arrangements			
3.	Fan & ventilation			
4.	Drinking water			
5.	Toilet			

a. Are there toilet facilities available & functioning? (Yes/No))

b. Are they kept clean? (Yes/No)

c. When you/your family members are sick, where do you prefer to go?

a. PHC/Taluk Hospital/District Hospital/Private clinic or nursing home/  
Ayurvedic or Homeopath/Informal local healer

- d. If they do not prefer to go to government hospital (PHC/TH/DH), why? Give reasons
- e. If conditions at PHC/TH/DH are not satisfactory, have you given complaints?

If YES,

Whom have you taken your grievances to?

PHC MO/ GP Adhyaksha or member/ MLA / Local leader/  
Village head/any other

If NO, why have you not complained?

- a. They do not listen
- b. No use of complaining
- c. Do not know to whom give complain
- d. Will go to private, do not bother to complain
- e. Any other reason

## ANNEXURE-26

### SCHEDULES - I, II, and III (Karnataka Panchayati Raj Act, 1993)

#### SCHEDULE - I (Gram Panchayat)

##### I. General Functions:

- 1) Preparation of annual plans for the development of the Panchayat area.
- 2) Preparation of annual budget.
- 3) Providing reliefs in natural calamities.
- 4) Removal of encroachments on public properties.
- 5) Organising voluntary labour and contribution for community works
- 6) Maintenance of essential statistics of the villages.

##### II. Agriculture, including Agricultural Extension:

- 1) Promotion and development of agriculture and horticulture.
- 2) Development of waste lands.
- 3) Development and maintenance of grazing lands and preventing their unauthorised alienation and use.

##### III. Animal Husbandry, Dairying and Poultry:

- 1) Improvement of breed of cattle, poultry and other live-stock.
- 2) Promotion of dairy farming, poultry and piggery.
- 3) Grassland development.

##### IV. Fisheries:

Development of fisheries in the villages.

##### V. Social and Farm Forestry, Minor Forest Produce, Fuel and Fodder:

- 1) Planting and preservation of trees on the sides of roads and other public lands under its control.
- 2) Fuel plantations and fodder development.
- 3) Promotion of farm forestry.
- 4) Development of social forestry.

## **VI. Khadi, Village and Cottage Industries:**

- 1) Promotion of rural and cottage industries.
- 2) Organisation of conferences, seminars and training programmes, agricultural and industrial exhibitions for the benefit of the rural areas.

## **VII. Rural Housing:**

- 1) Distribution of house sites within Grama thana limits.
- 2) Maintenance of records relating to the houses, sites and other private and public properties.

## **VIII. Drinking Water:**

- 1) Construction, repairs and maintenance of drinking water wells, tanks and ponds.
- 2) Prevention and control of water pollution.
- 3) Maintenance of rural water supply schemes.

## **IX. Roads, Buildings, Culverts, Bridges, Ferries, Waterways and other means of Communication:**

- 1) Construction and maintenance of village roads, drains and culverts.
- 2) Maintenance of buildings under its control or transferred to it by the Government or any public authority.
- 3) Maintenance of boats, ferries and waterways.

## **X. Rural Electrification, including Distribution of Electricity:**

Providing for and maintenance of lighting of public streets and other places.

## **XI. Non-Conventional Energy Source:**

- 1) Promotion and development of non-conventional energy schemes.
- 2) Maintenance of community non-conventional energy devices, including bio-gas plants.
- 3) Propagation of improved chullahs and other efficient energy devices.

## **XII. Poverty Alleviation Programmes:**

- 1) Promotion of public awareness and participation in poverty alleviation programmes for fuller employment and creation of productive assets, etc.
- 2) Selection of beneficiaries under various programmes through Gram Sabhas.
- 3) Participation in effective implementation and monitoring.

**XIII. Education, including Primary and Secondary Schools:**

- 1) Promotion of public awareness and participation in primary and secondary education.
- 2) Ensuring full enrollment and attendance in primary schools.

**XIV. Adult and Non-Formal Education:**

Promotion of adult literacy.

**XV. Libraries:**

Village libraries and reading rooms.

**XVI. Cultural Activities:**

Promotion of social and cultural activities.

**XVII. Markets and Fairs:**

Regulation of fairs (including cattle fairs) and festivals.

**XVIII. Rural Sanitation:**

- 1) Maintenance of general sanitation.
- 2) Cleaning of public roads, drains, tanks, wells and other public places.
- 3) Maintenance and regulation of burning and burial grounds.
- 4) Construction and maintenance of public latrines.
- 5) Disposal of unclaimed corpses and carcasses.
- 6) Management and control of washing and bathing ghats.

**XIX. Public Health and Family Welfare:**

- 1) Implementation of family welfare programmes.
- 2) Prevention and remedial measures against epidemics.
- 3) Regulation of sale of meat, fish and other perishable food articles.
- 4) Participation in programmes of human and animal vaccination.
- 5) Licensing of eating and entertainment establishments.
- 6) Destruction of stray dogs.
- 7) Regulation of curing, tanning and dyeing of skins and hides,
- 8) Regulation of offensive and dangerous trades.

**XX. Women and Child Development:**

- 1) Participation in the implementation of women and child welfare programmes.
- 2) Promotion of school health and nutrition programmes.

**XXI. Social Welfare, including Welfare of the Handicapped and Mentally Retarded:**

- 1) Participation in the implementation of the social welfare programmes, including welfare of the handicapped, mentally retarded and destitute.
- 2) Monitoring of old-age and widow pension schemes.

**XXII. Welfare of the Weaker Sections and in Particular the Scheduled Castes and Scheduled Tribes:**

- 1) Promotion of public awareness with regard to welfare of Scheduled Castes, Scheduled Tribes and other weaker sections.
- 2) Participation in the implementation of the specific programmes for the welfare of the weaker sections.

**XXIII. Public Distribution System:**

- 1) Promotion of public awareness with regard to the distribution of essential commodities.
- 2) Monitoring the public distribution system.

**XXIV. Maintenance of Community Assets:**

- 1) Maintenance of community assets.
- 2) Preservation and maintenance of other community assets.

**XXV. Construction and Maintenance of Dharmashalas, Chatras and similar institutions.**

**XXVI. Construction and Maintenance of Cattle Sheds, Pounds and Cart-Stands.**

**XXVII. Construction and Maintenance of Slaughter Houses.**

**XXVIII. Maintenance of Public Parks, Playgrounds etc.**

**XXIX. Regulation of Manure Pits in Public Places.**

**XXX. Establishment and Control of Shandies.**

**XXXI. Such other functions as may be entrusted.**

## **ANNEXURE-27**

### **SCHEDULE - II**

#### **(Taluk Panchayat)**

#### **I. General Functions:**

- 1) Preparation of Annual Plans in respect of the schemes entrusted to it by virtue of the Act and those assigned to it by the Government or the Zilla Panchayat and submission thereof to the Zilla Panchayat within the prescribed time for integration with the District Plan.
- 2) Consideration and consolidation of Annual Plans of all Gram Panchayats in the Taluk and submission of the consolidated plan to the Zilla Panchayat.
- 3) Preparation of Annual budget of the taluk and its submission within the prescribed time to the Zilla Panchayat.
- 4) Performing such functions and executing such works as may be entrusted to it by the Government or the Zilla Panchayat.
- 5) Providing relief in natural calamities.

#### **II. Agriculture, including Agricultural Extension:**

- (1) Promotion and development of agriculture and horticulture.
- (2) Maintenance of agricultural seed farms and horticultural nurseries.
- (3) Storing and distribution of insecticides and pesticides.
- (4) Propagation of improved methods of cultivation.
- (5) Promotion of cultivation and marketing of vegetables, fruits and flowers.
- (6) Training of farmers and extension activities.

#### **III. Land Improvement and Soil Conservation:**

Assisting the Government and the Zilla Panchayat in the implementation of land improvement and soil conservation programmes of the Government.



#### **IV. Minor Irrigation, Water Management and Watershed**

##### **Development:**

- (1) Assisting the Government and Zilla Panchayat in the construction and maintenance of minor irrigation works.
- (2) Implementation of community and individual irrigation works.

#### **V. Animal Husbandry, Dairying and Poultry:**

- (1) Maintenance of veterinary and animal husbandry services.
- (2) Improvement of breed of cattle, poultry and other live-stock.
- (3) Promotion of dairy farming, poultry and piggery.
- (4) Prevention of epidemics and contagious diseases.

#### **VI. Fisheries:**

Promotion of fisheries development.

#### **VII. Khadi, Village and Cottage Industries:**

- (1) Promotion of rural and cottage industries.
- (2) Organisation of conferences, seminars and training programmes, agricultural and industrial exhibitions.

#### **VIII. Rural Housing:**

Implementation of housing schemes and distribution of house sites in villages outside Grama thana limits.

#### **IX. Drinking Water:**

- (1) Establishment, repairs and maintenance of rural water supply schemes.
- (2) Prevention and control of water pollution.
- (3) Implementation of rural sanitation schemes.

**X. Social and Farm Forestry, Minor Forest Produce, Fuel and Fodder:**

- (1) Planting and preservation of trees on the sides of roads and other public lands under its control.
- (2) Fuel plantation and fodder development.
- (3) Promotion of farm forestry.

**XI. Roads, Buildings, Bridges, Ferries, Waterways and other means of Communication:**

- (1) Construction and maintenance of public roads, drains, culverts and other means of communication which are not under the control of any other local authority or the Government.
- (2) Maintenance of any building or other property vested in the Taluk Panchayat.
- (3) Maintenance of boats, ferries and waterways.

**XII. Non-Conventional Energy Sources:**

Promotion and development of non-conventional energy sources.

**XIII. Poverty Alleviation Programmes:**

Implementation of poverty alleviation programmes.

**XIV. Education, including Primary and Secondary Schools:**

- (1) Promotion of primary and secondary education.
- (2) Construction, repair and maintenance of primary school buildings.
- (3) Promotion of social education through youth clubs and mahila mandals.

**XV. Technical Training and Vocational Education:**

Promotion of rural artisan and vocational training.

**XVI. Adult and Non-Formal Education:**

Implementation of Adult Literacy.

**XVII. Cultural Activities:**

Promotion of social and cultural activities.

**XVIII. Markets and Fairs:**

Regulation of fairs and festivals.

**XIX. Health and Family Welfare:**

- (1) Promotion of health and family welfare programmes.
- (2) Promotion of immunisation and vaccination programmes.
- (3) Health and sanitation at fairs and festivals.

**XX. Women and Child Development:**

- (1) Promotion of programmes relating to development of women and children.
- (2) Promotion of school health and nutrition programmes.
- (3) Promotion of participation of voluntary organisations in women and child development programmes.

**XXI. Social Welfare, including Welfare of the Handicapped and Mentally Retarded:**

- (1) Social welfare programmes including welfare of handicapped, mentally retarded destitutes.
- (2) Monitoring the old-age and widow pensions and pensions for the handicapped.

**XXII. Welfare of the weaker sections and in particular, of the Scheduled Castes and Scheduled Tribes:**

- (1) Promotion of welfare of Scheduled Castes, Scheduled Tribes and other weaker sections.
- (2) Protecting such castes and classes from social injustice and exploitation.

**XXIII.Maintenance of Community Assets:**

- (1) Maintaining all community assets vested in it or transferred by the Government or any local authority or organisation.
- (2) Preservation and maintenance of other community assets.

**XXIV. Public Distribution System:**

Distribution of essential commodities.

**XXV. Rural Electrification:**

Promotion of rural electrification

**XXVI. Co-operation:**

Promotion of co-operative activities.

**XXVII. Libraries:**

Promotion of libraries.

**XXVIII. Such other functions as may be entrusted.**

## **ANNEXURE-28**

### **SCHEDULE - III**

#### **(Zilla Panchayat)**

#### **I. General Functions:**

Overall supervision, co-ordination and integration of development schemes at Taluk and District levels and preparing the plan for the development of the district.

#### **II. Agriculture (including Agricultural Extension) and Horticulture:**

- (1) Promotion of measures to increase agricultural production and to popularise the use of improved agricultural implements and the adoption of improved agricultural practices.
- (2) Opening and maintenance of agricultural and horticultural and commercial farms.
- (3) Establishment and maintenance of godowns.
- (4) Conducting agricultural fairs and exhibitions.
- (5) Management of agriculture and horticultural extension and training centres.
- (6) Training of farmers.

#### **III. Land Improvement and Soil Conservation:**

Planning and implementation of land improvement and soil conservation programmes entrusted by the Government.

#### **IV. IV. Minor Irrigation, Water Management and Watershed Development:**

- (1) Construction, renovation and maintenance of minor irrigation works.
- (2) Providing for the timely and equitable distribution and full use of water under irrigation schemes under the control of the Zilla Panchayat.
- (3) Watershed development programmes.
- (4) Development of groundwater resources.

#### **V. Animal Husbandry, Dairying and Poultry:**

- (1) Establishment and maintenance of taluk and village veterinary hospitals, first-aid centres and mobile veterinary dispensaries.
- (2) Improvement of breed of cattle, poultry and other livestock.
- (3) Promotion of dairy farming, poultry and piggery.
- (4) Prevention of epidemics and contagious diseases.

**VI. Fisheries:**

- (1) Development of fisheries in irrigation works vested in the Zilla Panchayat.
- (2) Promotion of inland, brackish water and marine fish culture.
- (3) Implementation of fishermen's welfare programmes.

**VII. Khadi, Village and Cottage Industries:**

- (1) Promotion of rural and cottage industries.
- (2) Establishment and management of training-cum-production centres.
- (3) Organisation of marketing facilities for products of cottage and village industries.
- (4) Implementation of schemes of State Boards and All-India Boards and Commissions for development of rural and cottage industries.

**VIII. Small-Scale Industries including Food-Processing Industries:**

Promotion of small-scale industries.

**IX. Rural Housing:**

Promotion of rural housing programme.

**X. Drinking water:**

Promotion of drinking water and rural sanitation programmes.

**XI. Minor Forest Produce and Fuel and Fodder:**

- (1) Promotion of social and farm forestry fuel plantation and fodder development.
- (2) Management of minor forest produce of the forests raised in community lands.
- (3) Development of wasteland.

**XII. Roads, Buildings, Bridges, Forest Waterways and other means of Communications:**

- (1) Construction and maintenance of district roads and culverts, causeways and bridges (excluding State Highways and village roads).
- (2) Construction of administrative and other buildings in connection with the requirements of the Zilla Panchayat.

**XIII. Non-Conventional Energy Sources:**

Promotion and development of non-conventional energy sources.

**XIV. Poverty Alleviation Programmes:**

Planning, supervision and monitoring the implementation of poverty alleviation programmes.

**XV. Education, including Primary and Secondary Schools:**

- (1) Promotion of educational activities in the district, including the establishment and maintenance of primary and secondary schools.
- (2) Establishment and maintenance of ashram schools and orphanages.
- (3) Survey and evaluation of education activities.

**XVI. Technical Training, and Vocational Education:**

- (1) Establishment and maintenance of rural artisan and vocational training centres.
- (2) Encouraging and assisting rural vocational training centres.

**XVII. Adult and Non-formal Education:**

Planning and implementation of programmes of adult literacy and nonformal education programmes.

**XVIII. Markets and Fairs:**

Regulation of important fairs and festivals in the district.

**XIX. Health and Family Welfare:**

- (1) Management of hospitals and dispensaries under the management of Government or authority.
- (2) Implementation of maternity and child health programmes
- (3) Implementation of family welfare programmes.
- (4) Implementation of immunisation and vaccination programmes.

**XX. Women and Child Development:**

- (1) Promotion of programmes relating to development of women and children.
- (2) Promotion of school health and nutrition programmes.
- (3) Promotion of participation of voluntary organisations in women and child development programmes.

**XXI. Social Welfare, including Welfare of the Handicapped and Mentally Retarded:**

Promotion of social welfare programmes, including welfare of handicapped, mentally retarded and destitute.

**XXII. Welfare of the weaker sections and in particular of the Scheduled Castes and Scheduled Tribes:**

- (1) Promotion of educational, economic, social, cultural and other interests of the Scheduled Castes, Scheduled Tribes and Backward Classes.
- (2) Protecting such Castes, Tribes and Classes from social injustice and all forms of exploitation.
- (3) Establishment and management of hostels of such Castes, Tribes and Classes.
- (4) Supervision and management of hostels in the district, distribution of grants, loans and subsidies to individuals and other schemes for the welfare of Scheduled Castes, Scheduled Tribes and Backward Classes.

**XXIII. Maintenance of Community Assets:**

- (1) Maintenance of community assets vested in it or transferred to it by the Government or any local authorities or organisation.
- (2) Assisting the Government in the preservation and maintenance of other community assets.

**XXIV. Cultural Activities:**

Promotion of social and cultural activities.

**XXV. Public Distribution System:**

**XXVI. Rural Electrification:**

**XXVII. Co-operation:**

Promotion of co-operative activities.

**XXVIII. Libraries:**

Promotion of libraries.

**XXIX. Such other functions as may be entrusted.**



## ANNEXURE-29

### Sample minutes of Standing committee of Gadag & Chamaraj Nagar district AND minutes of Taluk Panchayat, ARS meetings of Chamarajanagar District

#### ARS Meeting at Kuderu PHC, Chamarajanagara

**Date: 25-03-2013**

1. Discussed about utilization of the fund
2. Discussed about the 'Dengue Fever', and 'Chicken Gunia', precautions to be taken etc

**Date: 27-07-2013**

1. Informed about the money released during the year for ARS and untied fund
2. Repair of bore well done by medical Officer and decision made in ARS meeting to pay the expenses incurred to Medical Officer through Cheque.
3. Decision was made to buy fire safety equipments for the hospital and also payments to be done through cheque to the supplier.

**Date: 28-09-2013**

1. Review about the budget allocation and expenditure
2. Decided to pay Rs 6000/- from ARS fund to night duty nurse, Rs 26,072 towards lab equipments from untied fund and Rs. Rs 8680/- expenditure towards cleanliness and repair and maintenance from annual maintenance fund

**Date: 30-11-2013**

1. Review about the budget allocation and expenditure under the fund
2. Expenditure made towards surgical equipments, salary towards night duty nurse, electrical repair etc. As these are essential from the point of view of public service, post expenditure permission given.

**Date: 29-03-2014**

1. Discussed about the budget allocation and expenditure
2. Discussed about the materials and equipments purchased for the hospital- like bed covers, baby embrace warmer, AV batteries etc and repair and maintenance.

**Date: 26-04-2014**

1. Discussed about utilization of the fund of the previous year.
2. Discussed about the outbreak of malaria in some places and also discussed about both preventive and curative aspects.
3. Discussed also regarding the cleanliness.

**Date: 28-06-2014**

1. Informed the members regarding non release of the fund yet.
2. Medical officer talked about world environment day and importance of keeping the surroundings clean to prevent the outbreak of epidemics.

**Date: 23-08-2014**

1. Informed the members regarding non release of the fund yet
2. As a part of the World Breast Feeding Week, Medical Officer talked about the importance of breast feeding. Also he spoke about providing good nutrition to breast feeding mothers.

**Date: 25-10-2014**

1. Informed the members regarding non release of the fund yet.
2. Medical officer spoke about voluntary blood donation as well as possible diseases due to iodine deficiency.

**Health Issues discussed in Taluk Panchayat meeting**

**Date: 8-09-2014**

1. leprosy in tribal villages
2. Organizing health camps
3. Cleanliness awareness in villages

**Date: 18-10-2014**

1. Discussed regarding 46 cases of leprosy in Godemadudoddi village and various actions to be taken.
2. Various health camps organized in tribal villages
3. Regarding keeping the villages clean
4. Chlorinating water tanker every 2 weeks

5. Conducting ARS meeting at PHCs every month
6. Continuing mobile clinic under PPP with Karuna Trust

**Date: 10-12-2014**

1. Vacancy of doctors at PHCs
2. Outbreak of chikengunya and Dengue fever
3. Action taken regarding HIV Aids- Awareness camps organized.

**Date: 19-02-2013 Standing committee meeting of Education and Health**

1. Replacing the deputed doctor with full time in Honganur PHC.
2. Requesting the construction of Sub Center under NRHM
3. Proposal submission for additional toilet construction at Kabbali, Therakanambi, honganur, Santhamaralli, Ramapur, Hanur and Kamagere PHC.
4. Regarding requesting the Panchayat of Mahadeshwara Betta for allotting site for Doctor quarter construction

**Date: 13-06-2013 Standing committee meeting of Education and Health**

1. Approval of budget for 2013-14 under Health and Family Welfare and District AYUSH Programme

**Date: 31-10-2013 Standing committee meeting of Education and Health**

Issues discussed-

1. Deputation of nurse to vacant PHC Mullur
2. Regarding lack of cleanliness and equipments in maternity ward of Kollegal Taluk hospital
3. Review of MMR and IMR
4. Vacancy of doctor I Honganur PHC
5. Opening of new PHC in Agara and Mamballi in Yalandur and progress of the completion of construction of these PHCs
6. Provision of clean Drinking water in Yalandur hospital

**Date: 21-05-2014 Standing committee meeting of Education and Health**

Health Issues discussed:

Standing Committee member Mr B P Puttabuddi , enquired about the list of students who have health issues under 'Suvarna Aarogya Chetana' and also improvement of their health. District health officer said that health check up is done for 90.1% of the students (Rs 1,23,930 /-) out of which 2555 children have been sent to higher hospitals and 19 children have been sent to hospitals having Yashaswini network.

In the same meet, discussed about PHC management, vacancies, salary, PHC building repair etc

There was also discussion of Ayush hospital building.

**Date: 06-11-2014 Standing committee meeting of Education and Health**

Health Issues discussed:

DHO explained that to fill up 9 vacancy on contract basis, interview was called and only 3 attended the interview. All the 3 doctors awarded the contract and only two doctors reported for the duty.

Discussed about conducting the health camps in schools.

**GADAG**

**Date: 05-11-2013 Standing committee meeting of Education and Health**

1. DHO explained about maintenance of buildings, construction of 6 new building, repair and maintenance of equipments, tendering process for purchase of equipments.
2. DHO informed the committee regarding the sanction of Purchase of 5 ambulances under 'Nagu Magu' programme of NRHM. Sought permission of the committee for the allotment of these ambulances to different PHCs wherever they are needed most. Committee approved. Committee decided to allot these ambulances to 4 taluk hospitals ( namely Shirahatti, Naragunda, Rona and Mundargi) and one CHC at Laxmeshwar
3. Committee Adhyaksha proposed to construct PHC at Asundi village coming under PHC, Harti as the population is more. In the committee meeting, DHO has been asked to write a letter to the government regarding the same.

**Date: 04-09-2014 Standing committee meeting of Education and Health**

1. Approving the action plan of the health for the year.

**Date: 20-12-2014 Standing committee meeting of Education and Health**

- DHO placed the progress of the different schemes under the health department before the committee.
- Committee A dhyaksha told DHO to start the process of tendering to purchase equipments under the Karnataka transparency act.
- AYUSH officer sought the approval of the committee to purchase medicines through Karnataka logistic society. It also sought approval to buy Homeopathic medicines from Kerala State Cooperative Pharmacy Limited. Committee approved to buy the medicines.