

**A STUDY
ON
EFFECTIVENESS OF
PANCHAYATI RAJ INSTITUTIONS (PRIs)
IN
HEALTH CARE SYSTEM IN THE STATE OF
MADHYA PRADESH: IMPACT OF DUALITY AND
ROLE OF BUREAUCRACY IN NEW APPROACHES**



**SHRI RAM CENTRE
FOR INDUSTRIAL RELATIONS, HUMAN RESOURCES, ECONOMIC AND
SOCIAL DEVELOPMENT**

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and conducted by Shri Ram Centre for Industrial Relations & Human Resources

MAY 2016

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EXECUTIVE SUMMARY

E.1 Introduction

In keeping with the spirit of concept of human development Constitution of India in 1992 gave the principal and onerous responsibility of enhancing health status of rural people in India to the Panchayati Raj System, the Planning Commission, Government of India, New Delhi has assigned a Research Study on “Effectiveness of Panchayati Raj Institutions (PRIs) in Health Care System in the State of Madhya Pradesh: Impact of Duality and Role of Bureaucracy in New Approaches” to Shri Ram Centre for Industrial Relations, Human Resources, Economic and Social Development in July 2011.

E.2 Objectives

Major objectives of the study are the following:

- Examine the present status of development of infrastructure facilities for health care delivery and their adequacy.
- Role of PRIs at each of the three levels as facilitators in enhancing the effectiveness of health care delivery services, and the impediments and constraints encountered by PRIs in the process.
- Assessment of the present level of satisfaction as perceived by the beneficiaries of rural health care delivery system.
- Identify and elaborate on success stories of the effectiveness of involvement of PRIs in the delivery of health care services, and highlight how the success stories may be replicated everywhere.
- Propose a model structure of rural health care services within the framework of Panchayati Raj System (PRS).

E.3 Scope of the Study

The study was restricted to 8 districts in Madhya Pradesh (M.P.) distributed to represent different geographical distribution and demographic and socio-economic features. The districts were selected in consultation with the State Government. In each district, in consultation with the local officials, one Janpad Panchayat with high level of involvement.

in promoting health care was selected. In each Janpad Panchayat one Gram Panchayat was selected to ascertain the aspirations and expectations and level of satisfaction of the beneficiaries vis-à-vis health care services made available under the National Rural Health Mission (NRHM). Treating the Gram Panchayat as the base, the Sub-centre (SC), the Primary Health Centre (PHC), and the Community Health Centre (CHC) associated with the selected Gram Panchayat; and the districts health mission were covered. In each district (including the Zila Parishad), Janpad. Panchayat and Gram Panchayat the concerned officials, elected representatives and NGOs available were covered:

In each SC, PHC, and CHC;

- The health officials present on the day of the visit and;
- Benefits were covered taking into account the fact they should have attended at least one meeting of the Gram Sabha during the last one year.

E.4 Methodology

Among the PRI selected institutional framework, practices and processes were investigated with focus on roles, function, problems and perspectives of;

- Government functionaries
- Elected representatives; and
- NGOs and parallel bodies.

In addition roles, functions and perceptions of Standing Committees of PRIs, dealing with health care were investigated. Beneficiaries perceptions of role and effectiveness of PRS in the delivery of health care were taken.

The investigations were a combination of open-ended interviews with series of checklists, guided conversations and relating short answers to specific Questions in the formats prepared for the study.

In addition studies conducted in other states and literature available on the subject study were reviewed.

Field investigations were spread over a period of 6 months from November 2011 to April 2012.

Selection of Respondents

In all 177 respondents were selected for the study. The selection of respondents could not be done on a scientific sampling technique as the universe was amorphous and as per the terms of reference of the study, 20 respondents were to be taken from each district.

The criterion for selection of respondents was as follows;

1. They should be aware of the Panchayati Raj System.
2. They should be from the villages in which Gram Sabha meetings were held.
3. They have an awareness of the GPS meetings or have attended the Gram Sabha meeting..

E.5 Summary and Conclusions

Madhya Pradesh Government tilted it in its own favor by pursuing the policy of establishing a separate Zilla Sarkar at the district level with a Minister-in-charge appointed by State Government as its head and Zilla Panchayat President as its member. This step put Zilla Panchayats under the Zilla Sarkar when the opposite should have happened.

In the Zilla Sarkar (District Government) model of administration, the scope of District Planning Committees (DPCs) was enhanced from their primary task of planning to execute the tasks assigned to them by State Government. PRIs were primarily entrusted with the task of monitoring, supervision and implementation through line departments.

E.5.1 Present State of infrastructure facilities and their adequacy.

E.5.1.1 Buildings and Equipment

Both the physical and human resource infrastructure was insufficient at SCs and PHCs. X-ray machine was available in two PHCs and only two SCs had proper labour rooms and baby warmers. All others did not have even baby warmers and labour rooms at the SCs. This hindered institutional delivery services, which constitute a major activity at SC level. Timely identification of danger signs and complications of expectant mothers is also posing a problem.

In-patient wards at many PHCs are in a poor state and need for considerable improvement.

Operation theaters (OTs) at nearly half of the CHCs visited are just dumping grounds. The equipment available is also non functional.

Monitoring and supervision is generally neglected area. There are no proper arrangements and protocols laid down for monitoring maintenance of infrastructure facilities/equipment made available at SCs, PHCs and CHCs. In two CHCs of the eight CHCs visited, the team observed that waste material like old files and records are stacked on operation tables of OTs.

All the district health missions and hospitals are well equipped. Maintenance of equipment, however, is a neglected area. The best district hospital observed was at Dhar which has rest rooms for wards of patients admitted and organized out patient treatment system. In-patient care at this hospital is good with an attaché mechanized and hygienic kitchen to serve clean food to patients.

E.5.1.2 Staff Support

It was observed that by and large human resource available at each SC is adequate. In fact the strength of ASHAs is more than the required at source places, However, visits by qualified doctors to SCs has been found to be very weak. Decentralized health care under NRHM requires visits by Qualified medical doctors to each SC at least three times in a week. This was just not taking place.

Staff in position in PHCs was less than the sanctioned positions and proposed norms for the deployment of medical manpower crucial manpower like AYUSH doctors, malaria assistants and pharmacists are in acute shortage. In one PHC, pharmacists were found to be in-charge of the concerned PHC. Many PHCs do not have qualified medical doctors. However, doctors from CHCs have been observed to be visiting the concerning PHCs twice in a week in order to meet the gap. At the same time there is undue deployment of non-medical manpower at PHC level.

Although CHC are visualized as the first curative health service providers, there was an acute shortage of specialist services at CHC level. In two CHCs, there were lady surgeons but none in the other six. In 6 out of 8 CHCs surveyed, care facilities were missing in the 6 CHCs. Adequate trained technicians for lab test facilities were however deployed.

At the district level, in most of the districts, sanctioned positions of medical manpower had not been filled up. There was also acute shortage of specialist doctors at the district level. Non-medical manpower were in excess of sanctioned positions in 4 out of the 8 districts surveyed.

E.5.2 Role of PRIs as facilitators in enhancing effectiveness of health care delivery services and impediments encountered therein

Although PRs is designed to permit people to exercise their choice on the extent of public health system (PHS) services they would like to have, in reality, PRIs have a weak linkage with the PHS institution at SC, PHC and CHC levels. The elected members as also many of the bureaucrats manning PRIs were not aware of their roles and responsibly vis-à-vis PHS. Most of the functionaries of PRIs were of the view that health care is the responsibility of the health department. As the ground situation reflected during investigations, the community needing health care services were mute spectators. PRIs and PHS have cordial relations only at the district level. At the SC and PHC level, although there are standing committees to promote PRIs and PHS, in many cases PRIs are not aware of their roles and responsibilities and are not serious about their associations with the public institutions delivering health care.

Constitution has empowered PRIs with clear control and command mechanism to regulate and exercise supervision of health care delivery. PRI role in the state of Madhya Pradesh has been diluted because of the Zilla Sarkar form of governance.

- In fact NRHM provides effective platforms for continuous interaction between PRIs, NGOs, CBOs and public health institution such as:
- Village Health and Sanitation Committee (VHSC) at Gram Panchayat level;
- Rogi Kalyan Samitis (RKS) at clusters of Gram Panchayat and Janpad Panchayat Samitis, and
- District Health Mission (DHM) at district level.

Of all these forums, only DHMs were observed to be functioning effectively. Even at DHM level, association of NGOs and CBOs was practically nil. PRS has various forums, including informal clubs and association, to interact with rural people on issues relating local socio-economic development. Unfortunately health care is not being treated as one of the socio-economic development issue.

Awareness and capability of PRI functionaries, including elected representatives, need to be enhanced through training and counseling. In these of Himachal Pradesh Self Help Groups (SHGs) are actively engaged in promoting health care of rural people through PHS.

E.5.3 Satisfaction/Dissatisfaction with the Health Care Services

A low percentage of respondents were using the health services at SC and PHC and the CHC levels. It was more because of the apathy of the services, including the absence of doctors at the as well as the inadequacy of specialists at the district level. Specifically, respondents responses indicated the following.

- ❖ Availability of Doctors is a major area of dissatisfaction in districts other than Bhopal and Tikamgarh.
- ❖ In Sidhi and Tikamgarh doctors care was a major concern.
- ❖ A low percentage of respondents were using the services of SCs, PHCs and CHCs.

- ❖ The satisfaction levels with the Sub Centers were the highest in Bhopal and Lowest in Morena. Other sub centers also had low levels of satisfaction with the services of the SCs.
- ❖ At the PHC level too, availability of doctors and doctors care was an area leaving to dissatisfaction amongst the respondents. In some PHCs like Sidhi and Tikamgarh, the level of dissatisfaction was highest.
- ❖ At the CHC level, While their dissatisfaction with the medical and paramedical staff and health was low across the districts (except Bhopal), it was the highest in Tikamgarh district particularly with respect to doctors and paramedic staff's availability and care by the doctors.
- ❖ At the CHC level majority of the respondents were dissatisfied with a wide range of services in Balaghat, Bhopal, Dhar, Morena and Sidhi CHCs.
- ❖ Doctors availability, care for the patients was a major area in most of the CHCs.
- ❖ There was a high level of dissatisfaction with the quality of health care services and reproductive health care.

E.5.4 Success Stories of effectiveness of involvement of PRIs and other parallel bodies in the delivery of health care services to rural people,

Ramnagar Gram Pachayat (GP) Samiti of Morena district took active interest in the SC located and made concerted efforts to mobilize resources from the small industrial establishments in the 8 k.m. stretch between Ramnagar and Guwalior to;

- Upgrade Ramnagar SC into PHC;
- Construct labour room and in-patient ward;
- Erect laundry wall around the PHC;
- Effect posting of Medical Officer and two contractual doctors; and
- Facilitate regular visits by a tuberculosis specialist, as one of the village under the GP has 90% people afflicted by tuberculosis
- Setting up an X-Ray clinic for use in diagnosis and treatment;
- Maintaining clean and tidy environment within the PHC and keeping all the equipment in good working condition;
- Adding one more ambulance.

Through concerted efforts by the local the GP and Panachayat Samiti, the Government of M.P. had approved upgradation of this PHC into a CHC and necessary budget was also sanctioned. The medical officer at Aamjhera has already been designated as the Block Medical Officer (BMO). The GP President and other members raised resources. Public contribution through donations was adequate enough to support for:

- Establishing a separate 6 bedded male in-patient ward;
- Increasing the bed strength of maternity ward from 6 to 12 with clean toilets and purified drinking water;
- Constructing 6 bedded rooms for the attendants of female patients with clean toilets and safe drinking water;
- Setting up a private ward, with nursing home like facilities, for females who can afford to pay Rs.100/- per day as charges;
- Starting ophthalmic and leprosy clinics within the PHC and facilitating visits by the concerned specialists thrice in a week;

PRIs have failed to develop, supervise and regulate delivery of health care services. PRI functionaries were in fact of the view that health care delivery is the responsibility of the health department and not of the PRS. Except at the district level, at all other levels below the district there is practically no interaction between PRIs and PHC. If invited, PRI functionaries attend meetings of VHSC and RKS as a routine and do not actively take part in the meeting to tackle relating health care issues and provide proper direction reflecting the aspirations of people. This apathetic attitude towards PHS is because of lack of awareness of the constitutional provisions vis-à-vis responsibilities of PRIs and poor capability. Many PRIs do not take interest in drafting agenda for VHSC and RKS. In this respect PRIs wholly depend on the PHS institutions to take initiative. After scrutinizing the agenda papers and decision at VHSC and RKS, the study team is of the opinion that they do not reflect the aspirations of local people. Grievance redressal mechanism for health care services is a neglected area.

Rural people are generally dissatisfied with the service delivery at SC, PHC and CHC. As there are no forums other than PRIs, who do not reflect their opinions and aspirations, people have remained mute spectators.

E.5.5 Model Structure of Rural Health Care Within the Framework of Panchyati Raj System

The Model structure is proposed with the following objectives;

To enable community and community based organizations to provide feedback on Community health needs; Functioning of various state institutions under PHS; and identifying gaps, deficiencies and levels of community satisfaction in such a way that it facilitates corrective action.

To promote public-private partnership to indent the services of available local medical practitioners and specialists through a transparent system of accreditation and enlisting in the roster of personnel to deliver quality health services at agree costs and norms.

To restructure deployment of doctors.

In order to fulfill these objectives specific enabling actions have been suggested on the lines of;

- Provision of assured availability of funds of the PRIs;
- Enlisting cooperation NGOs in: Building up awareness among all stake holders; Encouraging transparency and accountability; Capacity building of PRI functionaries; Aiding participation of SCs, PHCs and CHCs in decentralized health care planning and delivery of relevant services; Activating PRIs into constructive discussions on nutrition, sanitation and health care;
- Providing independent assessment of PHS facilities to facilitate improvement;
- Standardization of quality health services;
- Encouraging preparation of reports on health status and issues of local people by PHCs and CHCs within their jurisdiction;
- Enforce discipline, responsibility and accountability in the procurement and distribution of medicines

Keeping in view the objections and enabling action suggested, tasks to be performed at each level of PHS institution have been proposed.

- In the proposed work SCs and PHCs will focus on establishing firm linkages with rural people at the grass-root level, build up awareness of PHS facilities, improve their access to PHS institutions, and continue to providing primary health care including Antenatal Care Services, Postnatal Care Services, Home Delivery, New Born Care and Child Health Care Services) and continue to providing primary health care and facilitating out reach to higher level PHS institutions;
- CHCs will provide hospitalization services to all the rural patients requiring out-patient and in-patient facilities;
- District Health Missions (DHMs) should play a pivotal role in decentralized planning, implementation, and monitoring and evaluation of health care delivery with the rural areas of the district Internal audit of DHM, CHC, PHC and SC should be outsourced.
- DHM should assist their respective Divisional Office in regular and periodic performance audit and Social Audit of the Quality and extent of coverage of PHS facilities.
- Divisional level will have a crucial role in Accounts and financial management; procurement, storage and logistics of distribution of medicines and equipment; administration and planning integrated health care delivery; maintenance and development of infrastructure facilities; improving association of NGOs and CBOs with health care planning, implementation, monitoring and evaluation and periodic review of all PHS institutions in each district under their jurisdiction; and establishing resource group of local specialist doctors, medical practitioner so that they can be deployed at the appropriate level of PHS institutions as per need for diagnosis and treatment of ailments of rural people at respective locations.

A framework for social audit of health care delivery of the NRHM has been suggested.

E.5.6 Recommendations

Recommendations Emerging from the Study

- Devolve finances and executive power to the three levels, in particular the GPs, along with implementation and monitoring. Even the latter two functions should be strengthened.
- Augment finances for health at the GP level.
- Sensitize GP members that health care is also an agenda of the panchyats and not the health officials. They should be prodded to raise genuine health issues of the villages in the meetings.
- Ensure that prospective health plan emerges from GPs. For that funds for health must be made available only then it becomes an agenda item of the GP meetings.
- Devolve health functionaries to PRI institutions with powers postings, transfers, appraisal and promotions.
- Sub-Centres must provide health services beyond maternity and child care.
- Capacity augmentation through local resources like the NGOs as well as Doordarshan amongst others.
- Ensure parity between the sanctioned and available strength particularly that of the medical staff.
- Make sure that the PRI and the health officials place sufficient emphasis on preventive health care at all the three levels.
- Improvements in Physical infrastructure and their upkeep.
- Provision of medical equipment and facilities like X-Ray, lab. Tests etc. in all the PHC and CHCs machines and other

General Recommendations

- Make Zilla Panchyats the supreme body for the provision of health in the district.
- The three tiers of PRI must work together and coordinate health efforts
- Shift from the Zilla Sarkar Model to the PRI Model.
- Develop a separate Cadre of PRI.
- Change in the attitude of Health Officials towards PRI officials by making them work under the later.
- Ensure Greater Role of the community by giving them powers to question PRI members and seek corrections.

Chapter 1

Introduction

1.1 Background

Given the centrality of material aspect of human existence to the development process, pathway to full utilization of human potentialities lies in the progressive improvement of human capacities¹. One of the main instruments to improve human capabilities, apart from education is health. Any development process which works through health has been observed to result in sustainable overall development². Health in the wider sense is thus both a means and one of the end products of development³.

Realizing the importance of health, Government of India launched the Primary Health Care (PHC) delivery system about three decade ago. Significant features of the PHC approach are the inter-sectoral collaboration and community participation⁴. Despite awareness of the need for more integrated approach to PHC services delivery, PHC retained separate identity. Around the time when Panchayati Raj System (PRS) was being ushered in, it was realized that PRIs can play a crucial role in effecting inter-sectoral collaboration. The concept of Human Development introduced by United Nations Development Programme (UNDP) in 1991 also emphasized that health care delivery should be a participative process⁵.

¹ Harold J. Bir/shady (ed.), **Max Schuler on Knowledge and Feeling**, Chicago University Press, Chicago, 1977, p.29; Charles Jaylor, **Growth, Legitimacy and Modern Identify**, Praxis Intimation, 1,2, July 1981, p.III; **Hegel and Modern Society**, Cambridge University Press, Cambridges 1970; and **Social Theory and Practice**; Oxford University Press, Delhi, 1983

² Sen, Amartya "Health in Development" **Bulletin of World Health Organization (WHO)**, 1999, 77(8)

³ Barker, C. **What does the Health Care do for the Society**, Nuffield Institute of Health, University of Leeds, U.K., CB/CO2HO, 1995 (mimeo)

⁴ Government of India, **Health for All by the Year 2000**, Ministry of Health and Family Welfare, New Delhi, 1981

⁵ **Human Development Report 1991**, published for the UNDP by the Oxford University Press, New York, p.1

Herein, the process should focus on empowering people to participate, negotiate, influence, control and hold accountable the institutional infrastructure designated to deliver PHC services⁶.

In keeping with the spirit of concept of human development, the 73rd and 74th amendments effected to the Constitution of India in 1992 (Constitution Act 1992) gave the principal and onerous responsibility of enhancing health status of rural people to the Panchayati Raj System (PRS). Health encompasses sanitation, hospitals, Primary Health Centres (PHCs) and dispensaries.

The following considerations appeared to have weighed in entrusting PRS with the responsibility of coordinating Health Care delivery to rural people:

- a) **PRS is a Development Agency.** Panchayati Raj Institutions (PRIs) are political institutions at the grass root level. They are autonomous and statutory elected bodies with a mandate for self-governance. The union government has entrusted PRIs with the responsibility to prepare and implement plans for economic development and social justice.
- b) **Localization of Planning and Implementation.** Popular authority at the lowest level performs planning functions: Identifying felt needs and aspirations of people, prioritizing and scheduling relevant actions, approving resource allocation, and monitoring implementation. Higher level authorities undertake simultaneously interdependent and complementary functions over geographically larger areas, and also provide policy support and resources to the local planning exercise⁷.
- c) **Peoples' Participation.** PRS is designed to facilitate peoples' participation in identifying their economic and social development needs and priorities, developing confidence and determination to achieve what they want, finding resources internally and externally to support development decisions taken by them, and inculcating cooperative and collaborative spirit⁸. Primary Health Care

⁶ Deepa Narayan, **Empowerment and Poverty Reduction, A Source Book**, The World Bank, Washington DC., 2002

⁷ Azis, A and Shenoy, P.V. "District Planning: Principles and their Organization", **Journal of Rural Development**, 16(4), 1997, pp. 575-588; Beininger, a. "Rural Development and Decentralized Planning: Who Should Participate and How?" **The administrator**, Vol. 36, 1991, pp. 95-111

⁸ Ross Murray J. and B.W. Lupin, **Community Organization: Theory, Principles and Practice**, Harper

- d) (PHC) designed for rural areas – based on the concept of people’s health in people’s hands – precisely emphasizes democratization of health services⁹.
- e) **Ability to Coordinate and Integrate.** Planning and implementation under PRS is a coordinated activity emphasizing spatial, sectoral, cross-sectoral, and vertical integration as also integration of Centrally Sponsored Schemes with local plans and integration with local resources¹⁰. PHC emphasizes coordination and integration of relevant departments/agencies at the planning and implementation levels.
- f) **Transparency and Accountability.** Systems to ensure transparency and accountability in the functioning of PRIs are in place. Social Audit and RTI Act are two major instruments in this regard.

For providing the health care services, Panchayati Raj Institutions (PRIs) are assigned the following major responsibilities:

- Creating physical infrastructure
- Supervision and monitoring activities relating to health care delivery
- Removing obstacles, if any, in the smooth functioning of delivery of health care services

However, due to variations in the legislative provisions in the structure and functioning of PRS in different states, different patterns of people’s participation in the functioning of PRS have emerged among the states. As a result, the degree of efficiency of PRS as an institution in designing and delivering health care services has varied from state to state.

and Row, New York, 2nd Edition

⁹ Banerji, D. **Health and Family Planning Services in India: An Epidemiological, Socio-Cultural and Political Analysis and a Perspective**, Lok Pashsh, 1986, New Delhi

¹⁰ **Planning at the Grass Root Level**, Ministry of Panchayati Raj, Government of India, New Delhi, March 2006, p.32.

1.2 Objectives

Major objectives of the study are:

- Examine the present status of development of infrastructure facilities for health care delivery, and their adequacy
- Study the existing role of PRIs at all levels as facilitators and identify impediments in enhancing effectiveness of health care delivery services
- Highlight the success stories of the effectiveness of involvement of PRIs and other parallel bodies in the delivery of health care services and suggest how these may be replicated elsewhere
- Assess the present level of satisfaction as perceived by the people in the functioning of PRIs and other parallel bodies as instruments in the delivery of health care services
- Propose a model structure of PHC services within the framework of PRS

1.3 Panchayati Raj System (PRS) in Madhya Pradesh (M.P.)

There shall be a Gram Panchayat (GP) for every village specified as a village. The Governor shall, by public notification, specify a village or group of villages to be a village for the purpose of the Madhya Pradesh Panchayat Raj Avam Gram Swaraj Adhiniyam, 1993 (called as the Act henceforth).

The Governor may, by notification, divide a district into blocks. The notification shall specify the name of every such block, its headquarters and the area comprised therein. For every block there shall be a Janpad Panchayat (JP) – the intermediary Panchayat - in the three tier Panchayat Raj System (PRS).

There shall be a Zila Panchayat (ZP) for every district.

1.4 Scope of the Study

As decided by the Planning Commission, the study was restricted to 8 districts in M.P. distributed geographically in the State. In each district one Janpad Panchayat and one Gram Panchayat, and CHC, PHC and Sub-centre associated with the selected Gram Panchayat were covered.

1.4.1 Criteria for Selection of Units Investigated

- a) Selection of districts was made in consultation with the State Government having regard to the geographical distribution, demographic, and socio-economic features (See Table 1.1 on page 9 for basic features of the selected district).
- b) In each selected district one Janpad Panchayat with high level of involvement in promoting health care was selected.
- c) In each Janpad Panchayat one Gram Panchayat was selected to ascertain the aspirations and expectations, and level of satisfaction of the beneficiaries vis-à-vis the health care services made available under the National Rural Health Mission (NRHM).
- d) Treating Gram Panchayat as the base, the Sub-centre, PHC and CHC associated with the selected Gram Panchayat; and the district health missions were covered.
- e) In each selected district (including the Zila Parishad), Janpad Panchayat and Gram Panchayat the officials, elected representatives and NGOs available were covered.
- f) In each Sub-centre, PHC and CHC
 - the health care officials present on the day of visit; and
 - beneficiaries accessible and able to respond were covered

Category-wise number of respondents covered in the eight districts is given at the end of this chapter.

Representativeness was ensured only in the selection of districts. It was not possible to ensure representativeness in the selection of Sub-centre, PHC and CHC. As per the terms and conditions of the study, the centre was to seek data from 20 persons districts with a total of 160 respondents. The study selected a total of 177 respondents from the

eight district. The respondents could not be selected strictly on the basis of multi-stage random sampling in view of the amorphous universe.

Table 1.1 Names of the Districts Selected for Investigation in M.P.

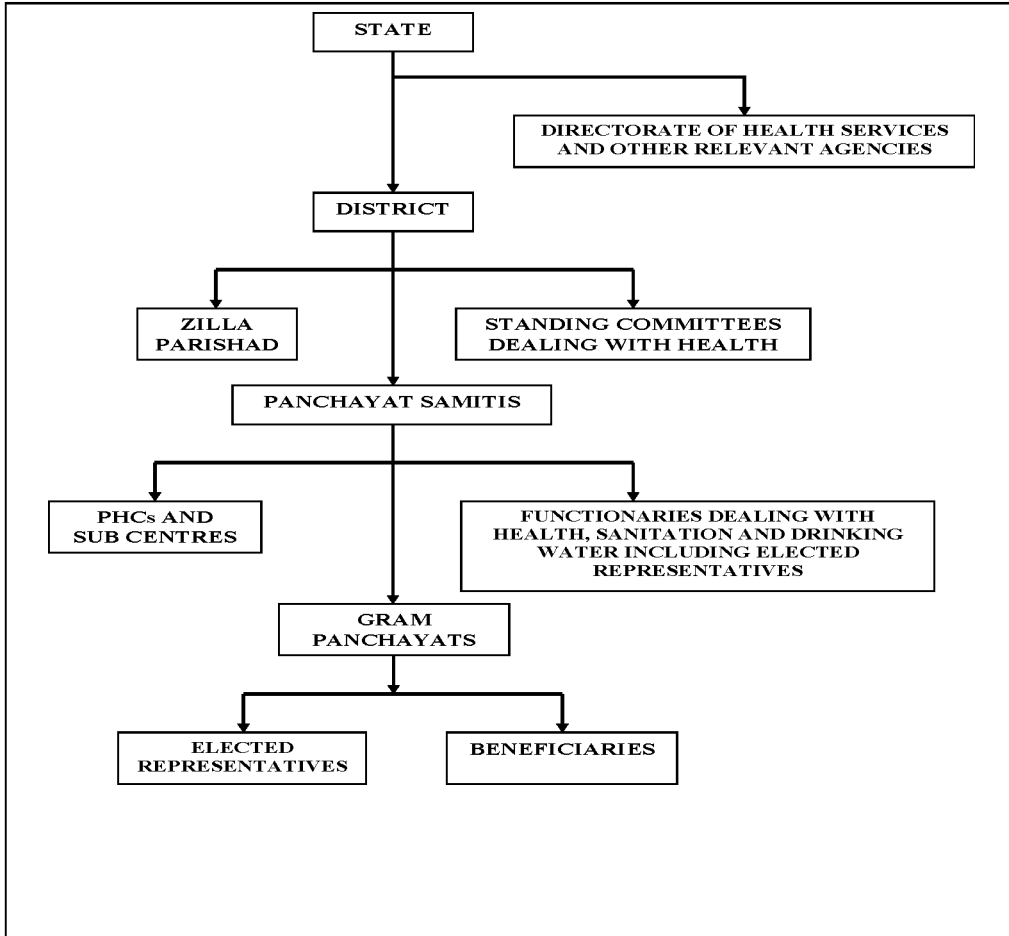
| SN. | NAME OF THE DIVISION | NAMES OF THE DISTRICT SELECTED | BASIC FEATURE OF THE DISTRICT |
|-----|----------------------|--------------------------------|---|
| 1 | Bhopal | Bhopal | Proximity to urban areas and the capital of the State |
| 2 | Indore | Dhar | Tribal dominated |
| 3 | Ujjain | Dewas | Densely populated |
| 4 | Gwalior | Morena | Disturbed district |
| 5 | Sagar | Tikamgarh | Backward district |
| 6 | Rewa | Sidhi | Tribal district |
| 7 | Jabalpur | Mandla | Disturbed district |
| 8 | Jabalpur | Balaghat | Disturbed district |

SRC however, followed in each district, at least one Community Health Centre (CHS), one Primary Health Centre (PHC), one Sub Centre were selected for detailed probe. (See Table 1.2 for the CHCs, PHCs and Sub-Centres selected). Apart from these, the district health mission was investigated in each district.

Table 1.2 List of CHC's, PHC's and Sub Centres Selected

| SN. | Districts | Districts Hospital | CHCs | PHCs | Sub Centres |
|-----|-----------|-----------------------------|--------------|---------------|----------------------------|
| 1. | Bhopal | Districts Hospital Bhopal | Gandhi Nagar | Fanda Kalan | Rapadia |
| 2. | Morena | Districts Hospital Morena | Kailarash | Ram Nagar | Rithora Kalan |
| 3. | Tikamgarh | District Hospital Tikamgarh | Pritwi Pur | Dighora Kalan | Jewra Mora and Birora Khet |
| 4. | Dewas | District Hospital Dewas | Bagli | Bhausara | Aranya Kalan |
| 5. | Dhar | District Hospital Dhar | Sardarpur | Aamjhera | Jaulana |
| 6. | Mandla | Districts Hospital Mandla | Bichiya | Ram Nagar | Dani Tola |
| 7. | Balaghat | Districts Hospital Balaghat | Khandangi | Lamta | Phulputta and Kotori |
| 8. | Siddhi | District Hospital Siddhi | Kaushumi | Aamaliya | Patpara |

Broadly speaking the study involved the following levels:



1.5 Methodology Followed

At the level of Zilla Parishad and Panchayat Samitis, institutional framework, practices and processes were investigated with focus on roles, functions, problems and perspectives of

- Government functionaries;
- Elected representatives; and
- NGO's and parallel bodies

In addition, roles, functions, problems, and perceptions of standing committees of PRIs dealing with health were investigated.

In the GPs, the role and effectiveness of the PRS in the primary health care delivery services were probed in detail from the beneficiaries' point of view.

The objective was to develop a narrative of specific health care facilities and, opportunities for accessing them that are available and their efficiency in the delivery of needed services as perceived by all stake holders of the delivery system.

The investigations began with open ended interviews with officials managing health care services to understand the system in terms of its role and extent of involvement. The factors which stand in the way of effective delivery of primary health care services as perceived by the stake holders were probed in detail.

Interviews in qualitative research took the form of guided conversation. They ranged from flowing discourses with little guidance to relatively short answers to specific questions. It was important that the respondents narrated their tale in their own words

Researchers involved in the project developed interview schedules. The interview schedules developed by research team contained series of checklists under the open ended questions to remind the interviewer of possible points to be raise if the respondent does not do so spontaneously. In addition, structured questionnaires were developed to ascertain the perceptions of the beneficiaries in a graded manner. Design of investigations included structured discussions on a one-to-one basis and issue based focused discussions in groups among the respondents.

In addition, studies conducted earlier on the subject of the study were reviewed in the light of the findings of the present study.

Reference Period

Field investigations were planned for the period November 2010 to may 2011. However, due to logistics problems / convenience of local authorities, primary data collection was rescheduled from November 2011 to March 2012.

Statistical Design / Size of the Sample

- State Level - 4 Officials
- Zilla Parishad - Members of Standing Committee dealing with Health
- District Level - 12 Officials and Elected Representatives
- Panchayat Samiti - Members
- PHCs, hospitals and dispensaries - 12 Officials
- Gram Panchayat - 10 Beneficiaries

Major Variables for Data Collection

Data for the study was collected through secondary and primary sources.

Secondary Data covered the following aspects:

- Demographic features of the districts;
- Agenda, minutes and action taken at the meetings of PRIs on health care delivery;
- Resource allocation, disbursement and utilization by the PRIs for health and sanitation;
- Actual availability of the health care facilities like number of sub-centres, PHCs, average population served at Sub-Centres and PHCs, Doctors and paramedical staff in employment, functional linkages with PRIs, and monitoring and supervision structures;
- Total budget of the health care facilities and its disbursement;
- Institutions like Government, Agencies, NGOs, PRIs, etc. working for health;
- Operational expenses and sources of revenue

Primary Data

Primary data were collected through discussions and interviews covering a cross section of stake holders viz.

- Functionaries/elected people's representatives of the PRI's at all levels
- Functionaries of the concerned Government Departments and personnel directly employed in institutions like PHCs and others
- The customers i.e. the rural community for whom the services have been created

Investigation of Rural Population (the ultimate beneficiaries) focused on:

- Expectations of rural communities from PRIs and other parallel bodies;
- Satisfaction levels with the existing physical facilities and their technical and functional quality;
- mechanisms developed at the PRIs to handle rural people's grievances;
- approachability to the PRI representatives; and

- ethical issues in the provision of health care services such as corruption, malpractices, mis-management, and deliberate deprivation and/or discrimination.

Selection of Respondents

In all 177 respondents were selected for the study. The selection of respondents could not be done on a scientific sampling technique as the universe was amorphous and as per the terms of reference of the study, 20 respondents were to be taken from each district.

The criterion for selection of respondents was as follows;

4. They should be aware of the Panchayati Raj System.
5. They should be from the villages in which Gram Sabha meetings were held.
6. They have an awareness of the GPS meetings or have attended the Gram Sabha meeting..

Respondents Covered

Category-wise number of respondents covered in 8 districts is given in table 1.3.

Table 1.3 Category-wise number of Respondents Covered in 8 districts

| SN | Category of Persons Investigated | District | | | | | | | | Total |
|----|---|----------|--------|-------|------|--------|--------|-------|-----------|-------|
| | | Balaghat | Bhopal | Dewas | Dhar | Mandla | Morena | Sidhi | Tikamgarh | |
| 1 | Secretary (Panchayat Raj) | | 1 | | | | | | | 1 |
| 2 | Joint Director (Health)/Head Regional Training Centre | | 1 | | | 1 | | | | 2 |
| 3 | Joint Director (Regional) | | 1 | 1 | 1 | 1 | | | | 3 |
| 4 | Civil Surgeon District Hospital | 1 | - | 1 | 1 | 1 | | | 1 | 5 |
| 5 | Chief Medical and Health Officer (CMHO) | 1 | 1 | 1 | 1 | | 1 | | 1 | 6 |
| 6 | Specialists | | | 1 | 3 | | | 4 | 1 | 8 |
| 7 | Medical Officer | 1 | 1 | | 1 | | 3 | 2 | 1 | 9 |
| 8 | Lady Surgeon | | | 3 | | 2 | | | | 5 |
| 9 | Lady Medical Officer | | 3 | | | | | | | 3 |
| 10 | Block Medical Officer | 2 | 1 | | 3 | 1 | 1 | 2 | 1 | 11 |
| 11 | Malaria Inspector | | | | 1 | | | 1 | | 2 |
| 12 | Nutrition Officer | 2 | | 1 | 1 | 2 | 1 | 1 | 1 | 9 |
| 13 | Pharmacist | | | | | | 1 | | | 1 |
| 14 | Senior Staff Nurse | | | 2 | | | | | | 2 |

| | | District | | | | | | | | |
|----|-----------------------------------|----------|--------|-------|------|--------|--------|-------|-----------|-------|
| SN | Category of Persons Investigated | Balaghat | Bhopal | Dewas | Dhar | Mandla | Morena | Sidhi | Tikamgarh | Total |
| 15 | Staff Nurse | 5 | | | 2 | 4 | | 5 | 1 | 17 |
| 16 | Nursing Sister | | | | | | 1 | | 1 | 2 |
| 17 | Auxiliary Nurse and Midwife (ANM) | 4 | 2 | 2 | 5 | 1 | | 2 | 3 | 19 |
| 18 | Lady Health Visitor (LHV) | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 8 |
| 19 | Multipurpose Worker (MPW) | | 4 | | 3 | 1 | | | | 8 |
| 20 | Beneficiaries | 22 | 22 | 25 | 22 | 20 | 22 | 20 | 24 | 177 |
| 21 | ASHA | 4 | 2 | 2 | 4 | 6 | 4 | 5 | 6 | 33 |
| 22 | Aanganwadi Worker | 4 | 1 | 2 | 4 | | | 1 | 1 | 13 |
| 23 | Jt. Director (Panchayats) | | 1 | | | | | | | 1 |
| 24 | District Project Manager | 1 | 1 | | 1 | | | 1 | 1 | 5 |
| 25 | Block Project Manager | 1 | | 2 | | 1 | 1 | 1 | | 6 |
| 26 | Accountant | 1 | | 2 | | | | | | 3 |
| 27 | Other Administrative Staff | 4 | | 1 | | 1 | 1 | 2 | 2 | 11 |

| | | District | | | | | | | | |
|--------------|---|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|------------|
| SN | Category of Persons Investigated | Balaghat | Bhopal | Dewas | Dhar | Mandla | Morena | Sidhi | Tikamgarh | Total |
| 28 | Zilla Parishad a) CEO b) Other Officials c) Elected Representatives | | | | | | 1 | | | 1 |
| 29 | Janpad Panchayat a) CEO b) Other Officials c) Elected Representatives d) Janpad President | | 1 | | | | 1 | | 1 | 3 |
| | | 1 | | | | | | | | 1 |
| 30 | Gram Panchayat a) Secretary b) Elected Representative | 1 | | 1 | | | | | | |
| | | | 1 | | 4 | 3 | 1 | 1 | 2 | 14 |
| | | 1 | | 1 | | | | | | |
| | | | 1 | | 5 | 1 | 1 | 1 | 4 | 15 |
| Total | | 57 | 46 | 49 | 63 | 47 | 41 | 50 | 53 | 406 |

Chapter 2

Health Care by Sub Centres

2.1 Introduction

A Sub Centre is required to attend to the complete health needs of maternity and child care in the villages under its jurisdiction. Sub Centres are provided on the population norm of 1 per 5000 population in general areas and 1 per 3000 population in tribal / desert areas. A Sub-Centre (SC) thus covers a group of villages which includes the village where Gram Panchayat is located.

In the Indian Health Scenario, SC is a bridge between rural community and Public Health Care System. SC is responsible for providing primary health care and for making the services more responsive and sensitive to the rural community. Some SCs are designated as 'delivery points' wherein institutional delivery facilities are available, apart from extending help in the case of home deliveries. Other SCs extend help only in the case of home deliveries.

The Study Team covered 10 SCs spread over the 8 districts (Table 1.2). In these SCs the following categories of respondents were covered:

Table 2.1 Respondents Covered at the Sub Centre Level

| Category of Respondents Covered | Number Covered |
|---|--------------------|
| a) Auxillary Nurse and Mid wife (ANM) | 19 |
| b) Lady Health Visitor (LHV) | 8 |
| c) Accredited Social Health Activists (ASHAs) | 33 |
| d) Anaganwadi Worker (AWW) | 13 |
| e) Elected Representatives | 15 |
| f) Beneficiaries | 45 |
| | ----- |
| | Total:- 133 |
| | ----- |

2.2 Review of Services Delivery at Sub Centre Level

Service Delivery at Sub Centre level as stated earlier exclusively focused on Maternity and Child Health Care. Sub Centres facilitating institutional deliveries have Skilled Birth Attendants (SBAs).

Sub Centres in general provide the following Antenatal, Postnatal and child health care services;

- a) Antenatal Care Services (ANCSs): Registration (Within 12 weeks) Physical examination + weight + BP + abdominal examination; Identification and referral for danger signs; Ensuring consumption of at least 100 IFA tablets (for all pregnant women), 200 (for anemic women); Essential lab investigations (HB% urine for albumin/sugar, pregnancy test); TT immunization (two doses at an interval of one month); Counseling on nutrition, birth preparedness, safe abortion, Family and institutional delivery; Assured referral linkages for complicated pregnancies and deliveries, and severe anemia cases.
- b) Post Natal Care (PNC) Services; Institutional Delivery; Minimum 6 hours stay post delivery; Counseling for feeding, nutrition, family planning, Hygiene;

immunization and postal check up; Timely identification of danger signs and complications and referral of mother and baby.

- c) Home Delivery: Counseling for Feeding, Nutrition, Family Planning, Hygienic, immunization and postnatal check-up; Home visits on 3rd, 7th and 42nd day for both mother and baby. Additional visits are needed for the new born on day 14, 21 and 28. Further visits may be necessary for low birth weight (LBW) and sick newborns; and Timely identification of danger signs and complications, and referral of mother and baby.
- d) New Born Care Warmth; Hygiene and cord care; Exclusive breastfeeding for 6 months; Identification, management and referral of sick, low birth weight (LBW) and pre-term newborns; Referral linkages for management of complications; Care of LBW newborns < 2500 gm; and Zero day immunization OPV, BCG, Hepatitis B.
- e) Child Health Care; Immunization of Children from 6 vaccine preventable diseases; Addressing gap in the coverage of full immunization through UNCEF innovated Defaulter Tracking system at Sub Centres; Arresting the rate of severe malnutrition by providing requisite medical treatment, and counseling parents/guardians of malnourished children regarding significance of nutritional diet and in preparing nutritional diet from low cost and locally available foods. Most of the immunization services were administered in public health institutions.
- f) Chronic Disease Control Services: Care patients suffering from chronic diseases like cancer, mental health, diseases caused by use of Tobacco, Diabetes, Strokes, Cardiovascular Diseases, Deafness and Flores is almost nil at Sub Centres. However, control and alleviation of crucial chronic diseases such as Malaria, Kala Azar, Flarial, Cataract, Leprosy, Tuberculosis, Cholera and Hepatitis are addressed by the respective National Disease Control Programmes. In the districts surveyed, the most common diseases which are not attended to by the sub centres are water borne diseases, skin diseases caused by poor personal hygiene and health coupled with dust, and dog and snake bites. In fact, very rarely a doctor visits a Sub Centre. Hence, patients either suffer silently or go to District Hospital if they can afford.

Decentralization health care and NRHM requires visits by qualified doctors to each SC at least three times in a week.

2.3 Human Resource Support to Sub Centres

| Category of Manpower | Required Strength | *Number available as per the Survey per Sub Centre |
|----------------------|---|--|
| ANM | Atleast two (trained as SBA) of which one is always available at the headquarters of the Sub Centres | 1.9 |
| ASHA | One ASHA for every large Village / Habitat | 3.3 |
| Anganwadi Worker | One for every Anganwadi within a Gram Panchayat | 1.3 |
| Other workers | In addition Dais, Trained Birth attendants and Multipurpose Worker (Male) are posted where necessary As per need to assist ANM in Simple laboratory skills like Testing for anemia and some Curative skills | 1.0 |

*Total strength divided by the number of Sub-centres

It is of note that by and large human resource available per centre is adequate. In fact the strength at the level of ASHA is more than the required number.

Job Profile of ANM

- * Physical examination + weight + BP + abdominal examinations during ANC stage
- * Identification and referral of danger sign
- * Essential lab investigations
- * TT immunization
- * Counseling on nutrition, birth preparedness, family planning and institutional delivery
- * Referral of complicated pregnancies and deliveries to the authorized appropriate health institution
- * Intrauterine Device (IUD) insertion

- * Navjaat Sishu Suraksha Karyakram
- * Home based Newborn Care (HBNC)

2.4 Gram Panchayats and Health Care

Subject to the rules, as the State Government may make, in this behalf, the GPs shall have the following powers specifically in respect of public health facilities and safety: to regulate the offensive or dangerous trades; to maintain sanitation, conservancy, drainage, water works and sources of water supply; to regulate the use of water; to regulate slaughter of animals; to regulate establishment of workshops, factories and other industrial units; to ensure environmental control; and to carry out such functions as are necessary by or under the provisions of the relevant Act.

Functions of Gram Panchayat

It shall be duty of the Gram Panchayat to: prepare annual plans for economic development and social justice - including village Health Plan of Panchayat area and submission thereof to the Janpad Panchayat within the prescribed time for integration with the Janpad Panchayat Plan; ensure the execution of health schemes, works, projects entrusted to it by any law and those assigned to it by the Central or State Government or Zilla Panchayat or Janpad Panchayat; and exercise control over local plan resources and expenditure for such plans; and co-ordinate, evaluate and monitor activities of committees constituted by Gram Sabha.

2.5 Functioning of Village Health & Sanitation Committees (VHSC)

The NRHM visualizes the provisions of decentralized health care at grass root level and for this involvement of Panchayat Raj Institutions was considered to be important. An institutional arrangement of constituting Village Health and Sanitation Committees (VHSCs) headed by Pradhan of Gram Panchayat (GP) and by involving elected GP members was considered important for monitoring and implementation of health services at the village level and for improving the health facility with the slogan "people health in their hands".

VHSC will form the link between the Gram Panchayat (GP) and the community. The VHSC would be responsible for working with the Gram Panchayat to ensure that the

health plan is in harmony with the overall local plan. It is extended that this committee will prepare a Village Health Plan and maintain village level data, supervised by the Gram Panchayat. Engaging the Gram Sabha and other groups in planning and monitoring the Village Health Plan will presumably enforce transparency and accountability.

All the sub centres visited have VHSCs. Composition of VHSCs in M.P. is as under: Members of a Standing Committee of GP or Member of GP from the village concerned will be the chairperson of VHSC; Representatives of NGOs; Representative local Mahila Mandal; ASHA of the village; Aanganwadi Worker of local Aanganwadi; Local persons trained in public health; ANM of the Sub centre; Male worker of local sub centre; and Gram Panchayat Secretary / ANM of the Sub Centre is the Secretary of VHSC

The Study Revealed that where the GP Secretary is the Secretary VHSC, the concerned VHSCs have not been meeting for months although, it is mandatory for a VHSC to meet every month. Also, the agenda papers of VHSC meeting prepared by a GP Secretary focused more on non-health related issues like repair and maintenance of buildings and furniture and alterations and additional construction in the buildings. Agenda papers prepared by ANMs on the other hand focused more on issues relating to health and sanitation. This is because most of GP Secretaries are matriculates and do not have a proper perspective of health needs and health issues of the villages. Also, many GP Secretaries were found to be evading convening of VHSC meetings. Many of the GPs surveyed totally neglected their responsibility towards Health and Family Welfare (HFW) and focused their attention only on Sanitation. The GPs surveyed were of the view that health care is the responsibility of the health department. The GP of Jewra Mora of Tikamgarh district neglected even sanitation. Further, as reported by beneficiaries, there is rampant misuse of annual grant of untied funds due to lack of proper supervision and monitoring.

Effective health care is not within the realm of the health department alone. At the village level convergence is required with agencies providing nutrition, sanitation, education, livelihood/poverty alleviation and empowerment schemes at the very least. Beyond the functionaries of each of the line departments, the only institution at the village level which can coordinate all these functions is the PRI. In reality however there is little convergence at the village level in many states, much less an active role.

In two villages one in Morena district and the other in Bhopal district GPs have been very effective and succeeded in bringing about substantial improvements like;

- * upgrading sub centre to primary health centre;
- * facilitating provision of specialists services; and
- * mobilizing public support and donations to health care services at their respective centres

There was also indifference among the people in taking up healthcare issues in the gram sabhas. We found that almost everyone in our household survey and tracking study indicated dissatisfaction with the quality of health services and reproductive health care. Yet, they did not take up healthcare delivery issues in the Gram Sabha meetings. One of the main reasons for this was that the discussions in the gram sabhas were guided by the funds allotted for a particular purpose, and was not aimed at identifying needs of the community that would in turn guide prioritizing the spending. Discussions in most panchayats, therefore, were confined to activities for which money was available (such as provision of water, repairing village roads, poverty alleviation and so on). Since gram panchayats do not have any budgetary allocations for health or reproductive health care these issues were never discussed in the gram sabhas and gram panchayat meetings.

The Study Team covered 10 SCs spread over 8 districts of M.P. In all 133 respondents were covered at SCs levels very low percentage of beneficiaries surveyed used Sub Centre facilities, as they are mostly not satisfied with Sub Centre (Table 2.1 and 2.2 refer).

Service Delivery at SC level focuses entirely on Maternity and Child Health Care facilities. There is need to focus on common local diseases like water bone diseases and skin diseases. Also, emergency treatment is not readily available for ailments like dog and snake bites at SCs level. SC is the first point of contact for rural patients. Hence, they need to be more attentive and responsive.

SCs are exclusively managed by paramedical staff. There is a dire need for visits by qualified doctors to Sub Centres at least three times in a week.

ASHA's role has been extremely important both as paramedical staff and as Social Engineers in as much as they motivate, transform attitudes, buildup confidence and opinions of rural women.

There is dire need for GPs and VHSCs to get actively involved in ensuring that the public health and family welfare activities duly respond to people's needs. Ram Nagar GP of Morena district serves as a model in this regard. This GP has widened the scope of health care delivery, succeeded in upgrading local SC into PHC and facilitated adequate staff support including doctors to the upgraded PHC (See Appendix 2 for success stories).

2.7 Beneficiaries Perception on the Functioning of Sub Centres

The beneficiaries were asked if they had used the services of the SCs during the last one year. Beneficiaries, by and large, were not using the facility of Sub-Centers. Beneficiaries are generally not satisfied with health care services of the Sub Centres. They were also not satisfied with the infrastructure, the referral services and care and attention given by both the medical and the paramedical staff (Table 2.2).

Table 2.2 Perception of Beneficiaries using Sub Centres

| Nature of Facility | Satisfaction level of Beneficiaries at Sub-Centres by Districts | | | | | | | |
|--|---|--------|-------|------|--------|--------|-------|-----------|
| | Balghat | Bhopal | Dewas | Dhar | Mandla | Morena | Sidhi | Tikamgarh |
| A) At Sub Centre | | | | | | | | |
| Satisfied with health facilities | 17 | 47 | 11 | 11 | 20 | 5 | 12 | 14 |
| Satisfied with Infrastructure | 17 | 47 | 11 | 11 | 17 | 5 | 12 | 14 |
| Paramedical Staff are adequate | 14 | 47 | 14 | 11 | 17 | 5 | 8 | 7 |
| Paramedical Staff attend regularly | 12 | 47 | 14 | 13 | 20 | 5 | 8 | 7 |
| B) At Referral Centres | | | | | | | | |
| Doctors are available | 17 | 47 | 11 | 13 | 17 | 5 | 12 | 14 |
| Doctors attend regularly | 14 | 47 | 14 | 13 | 17 | 5 | 12 | 14 |
| Doctors care for all patients and do not discriminate | 14 | 47 | 14 | 13 | 18 | 5 | 8 | 8 |
| Percentage of Beneficiaries Surveyed using Sub Centre facilities | 27 | 47 | 25 | 23 | 30 | 9 | 20 | 21 |

Chapter 3

Health Care by Primary Health Centers

3.1 Introduction

Primary Health Centre (PHC) is visualized as the most effective intervention to achieve optimal level of Quality Health Care thereby effecting significant improvements in health status of population in the locality it serves. Activities of PHC include curative, preventive and promotive health care as well as family welfare services.

PHCs are currently provided on the population norm of 1 per 30,000 population in general areas and 1 per 20,000 population in tribal / desert areas. PHC is structured be a 24-hour facility with nursing services. Select PHCs in remote areas may be upgraded to provide 24-hour emergency hospital care as well.

The Study Team covered 8 PHCs – one in each of 8 districts covered (Table 1.2). In these PHCs the following respondents were covered.

Table 3.1 Respondents Covered at the PHC Level

| Category of Respondents | Number Covered |
|----------------------------|----------------|
| a) Medical Officer | 6 |
| b) Staff Nurse | 2 |
| c) ANM | 4 |
| d) LHV | 2 |
| e) ASHA | 5 |
| f) Pharmacist | 1 |
| g) Accountant | 1 |
| h) Gram Pradhan | 1 |
| i) Elected Representatives | 5 |
| j) Beneficiaries | 41 |
| Total :- | 68 |

3.2 Review of Service Delivery at PHC Level

All the PHCs surveyed were functioning from own buildings. Six of these PHCs had pharmacists and had adequate medicines. Two of these PHCs had homeopathic medicines and a homeopathic pharmacist as well. One of the PHCs surveyed had homeopathic doctors as medical officer. All the PHCs had separate labour rooms. Two of the PHCs had OT and casualty facilities. Drinking water was available in all PHCs. All the PHCs had OPD services and IPS services with 6 beds each. One of the PHCs had separate male ward with 4 beds. One of the PHC had nursing home facilities with four beds which can be availed on payment basis. ANC, PNC, new born care facilities and family planning services were available in all the PHCs. AYUSH services were not available in 6 of the 8 PHCs surveyed. The other two also had only homeopathic services. School health programme is being implemented in all PHCs. All the PHCs surveyed have referral services with Janani Express Transport facility 24X7 in order to bring pregnant women and new born children to Basic Emergency Obstetric and New Born Care (BEONC) and comprehensive emergency obstetric and new born care (CEMONC) facilities. For this purpose transport is hired locally on contractual basis for a period of one year on the basis of outsource criteria to establish effective communication. The contractual driver has a mobile whose number is predominantly displayed on the notice board of every PHC (See Table 3.2).

Maintenance of and hygiene and sanitation facilities was found to be satisfactory in five out of eight PHCs. Also Medical Officers were visiting PHC's once in a month only in two of the PHC's studied.

Table 3.2 Primary Health Centres and Related Facilities in the 8 Districts Surveyed in M.P.

| Sl.No. | Nature of Facility | Codes of Districts Selected | | | | | | | |
|--------|---|-----------------------------|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 1 | Own Building | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 2 | Drinking Water Availability | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 3 | Electricity supply | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 4 | Toilet facility | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 5 | Good cleanliness | 1 | 1 | 1 | 1 | 1 | - | - | - |
| 6 | Registration counter | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 7 | Pharmacy | 1 | 1 | 1 | 1 | 1 | 1 | 1 | - |
| 8 | Prominent display board in local language | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 9 | OPD Room | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 10 | Family Welfare Clinic | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 11 | Labour Room | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 12 | Operation Theatre (OT) | 1 | - | - | 1 | - | - | - | - |
| 13 | Adequate Equipment and chemicals availability | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 14 | Availability of adequate medicines | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 15 | Transport facility | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 16 | Communication facility | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 17 | Specialist services availability | - | - | 1 | 1 | 1 | 1 | - | - |
| 18 | OPD Services | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

1 = exists

- = does not exist

| Sl.No. | Nature of Facility | Codes of Districts Selected | | | | | | | |
|--------|--|-----------------------------|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 19 | Emergency Services | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 20 | Referral Services | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 21 | In Patient Service (IPD) Female | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 22 | In patient service (IPD) Males separately | - | - | - | 1 | - | - | - | - |
| 23 | ANC services | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 24 | PVNC services | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 25 | New Born Care | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 26 | Child Care & Immunization | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 27 | Family Planning services | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 28 | Nutrition services | 1 | - | - | - | - | - | - | - |
| 29 | School Health Program | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 30 | Disease surveillance and control services of epidemics | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 31 | Monitoring activities of ASHAs | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 32 | M.O. visit to all Sub centre at least once in a month | 1 | - | - | 1 | - | - | - | - |
| 33 | AYUSH only homeopathic services | 1 | - | - | - | 1 | - | - | - |

1 = exists

- = does not exist

Codes of District Selected: 1: Balaghat, 2: Bhopal, 3: Dewas, 4: Dhar, 5: Mandla, 6: Morena, 7: Sidhi, 8: Tikamgarh

An innovative scheme called Dhanwantari Block Development Scheme has been launched on a pilot basis in 50 blocks.

Obstetrics and Neonatal Care Services

All the ANC&PNC Services available at Sub Centre level are also available at PHC levels. In addition the following services are available;

- blood grouping & Retyping, Wet mount (Saline/KOH), RPR, VDRL; and
- management and provision of all basic obstetric and new born care including management of complication other than those requiring blood transfusion surgery

Four of the PHCs surveyed had specialist facilities available to attend to patients with diseases like tuberculosis, leprosy and opt holmic.

It must, however, be admitted that ANC, PNC and Child health care services dominated the services at PHC level.

3.3. Human Resource Support to PHCS

Sanctioned positions of medical manpower in all these districts is below the existing as also the proposed norms. Also, in many cases persons in place are less than the sanctioned positions. Crucial manpower like AYUSH doctors, malaria assistants and pharmacists are in acute shortage in Balaghat and Dhar districts. In some of the PHCs, pharmacists are in-charge of the PHC (Table 3.3).

Data on human resource support at PHC level could be obtained only in respect of 3 districts, despite concerted effort (See Table 3.3). Government of India (GOI) recognizes that improvements in the health outcomes in the rural areas is directly related to the availability of the trained human resources in the rural areas. Against the availability of one staff nurse at the PHC, it is proposed to provide three Staff Nurses to ensure round the clock services in every PHC. The Out-patient services would be strengthened through posting/appointment on contract of AYUSH doctors over and above the Medical Officers posted there. The States may consider integrating the services of AYUSH by relocation at PHC or by new contractual appointment. GOI support will be for all new contractual posts and not for existing vacancies that States have to fill up.

As per the existing and recommended staff support, there is no provision for locating specialists at PHC level. Yet, specialists like obstetricians and Gynecologists, Pediatricians and anesthetists were found working in Balaghat and Dhar districts. As per the proposed policy, specialists working in PHCs would be relocated at the Community Health Centres (CHCs) in order to improve Block level health infrastructure.

**Table 3.3 Human Resource Support at PHC levels per PHC by District Giving
Details of Sanctioned Positions (S) and Number in Place (P) in 2012**

| S.N. | Category of Manpower | Balaghat | | | Dewas | | | Dhar | | | Norms Specified as per the Mission Document @ | |
|------|----------------------------------|----------|------|------------|-------|-----|------------|------|------|------------|---|-------------------|
| | | S | P | (P/SX 100) | S | P | (P/SX 100) | S | P | (P/SX 100) | Existing Norm | Recommended Norm |
| 1 | Specialists | | | | | | | | | | | |
| | a. Obstetrician and Gynecologist | 0.03 | - | 0 | - | - | - | 0.1 | - | 0 | 0 | 0 |
| | b. Pediatrician | 0.03 | - | 0 | - | - | - | 0.03 | - | 0 | 0 | 0 |
| | c. Anesthetist | 0 | 0 | - | - | - | - | 0.03 | - | 0 | 0 | 0 |
| | d. Surgeon | | | - | - | - | - | - | - | - | 0 | 0 |
| 2 | Physician / Medical Officer | 0.5 | 0.2 | 40 | 1.8 | 1.4 | 77 | 1.2 | 0.74 | 62 | 1 | 1+1 (Lady Doctor) |
| 3 | AYUSH Doctors* | 0.06 | - | 0 | - | - | - | 0.1 | - | 0 | - | 1 |
| 4 | Staff Nurses | 0.20 | 0.12 | 60 | 0.5 | 0.1 | 30 | 0.6 | 0.4 | 70 | 1 | 3 |
| 5 | ANMs | 6.2 | 5.0 | 80 | 1.1 | 1.0 | 91 | 9.4 | 7.1 | 80 | | |

Continued.....2.....

| S.N. | Category of Manpower | Balaghat | | | Dewas | | | Dhar | | | Norms Specified as per the Mission Document @ | |
|--------------------------------|--------------------------|----------|------|------------|-------|-----|------------|------|-----|------------|---|---------------------------|
| | | S | P | (P/SX 100) | S | P | (P/SX 100) | S | P | (P/SX 100) | Existing Norm | Recommended Norm |
| 6 | LHVs | 1.0 | 0.4 | 40 | 0.8 | 0.8 | 100 | 0.1 | 0.1 | 100 | 1 | 1 |
| 7 | Lab Technicians | 0.12 | - | 0 | 0.2 | 0.2 | 100 | 0.3 | 0.2 | 67 | | |
| 8 | Pharmacists | 0.45 | 0.12 | 27 | 1.0 | 0.7 | 70 | 0.3 | 0.1 | 33 | 1 | 1 |
| 9 | Malaria Assistants | - | - | - | - | - | - | - | - | | - | - |
| 10 | ASHAs | 10.3 | 8.2 | 80 | - | - | - | - | - | | - | - |
| 11 | Other Para Medical Staff | 1.14 | 0.8 | 70 | 2.6 | 1.7 | 65 | 0.7 | 0.6 | 86 | 3 | 3 |
| 12 | Non Medical Staff | 14.4 | 8.2 | 57 | 4.0 | 2.8 | 70 | 3.8 | 2.6 | 68 | 7 | 6+1 (Out sourced drivers) |
| Number of PHCs in the District | | 36 | | | 22 | | | 46 | | | | |

Note: No information is available at PHC level in respect of the other 5 Districts: Bhopal, Mandla, Morena, Sidhi and Tikamgarh

Information given against AYUSH relates only to Homeopathic doctors @ National Rural Health Mission (2005-2012), Mission Document, Department of Health and Family Welfare, Government of India, New Delhi, 2008. pp. 192-93

The study revealed that infrastructure facilities available at PHC level are adequate. However, their maintenance, and care for hygiene and sanitation are below expectations.

ANC, PNC, child health care and family welfare services dominated the service spectrum at PHC level. Curative health care services are a neglected area. In tribal / disturbed and drought prone areas there is a dire need for emergency hospital care at PHC level, as other health care infrastructure is far removed. RKs have not been effective in facilitating good curative health care services. RKs is the medium through which PRIs can make effective intervention in health care development.

Sanctioned position of medical manpower is below the existing as also recommended manpower norms. In most cases even the sanctioned positions have not been filled up. This gave rise to acute shortage of medical manpower leading to poor delivery of health care service by PHCs.

Non-medical manpower deployment, on the other hand, is relatively higher than the medical manpower provided at PHCs. This causes drain in the scarce resources allocated to rural health care.

Inadequacy of funds to the PHC has been one of the important factors in the poor quality of services. The spending pattern had considerable implications for accountability in the provision of health services in general, and the reproductive health care in particular. The ambiguity in the separation of powers between the panchayats and the health departments, the overlapping areas of responsibility has contributed to ambiguity in accountability in health services. While the panchayats have the supervisory powers, the health department does not function in coordination with the panchayats. The health department functioned as a parallel structure. The staff do not consider themselves accountable to the panchayat, and their line of accountability is extended only to their department.

Most of the respondents were females. They have been using PHC services for maternity, child health care and referral services in case of complications and emergencies.

Beneficiaries perception (table 3.4) shows that although the percentage of beneficiaries availing PHC services during the last one year is much less, those satisfied with the PHC services is even lesser. Tribal / Disturbed districts appear to be using PHC services more than in the other districts. PHC services have been observed to be the lifeline for people in tribal/disturbed districts, as other health infrastructure is not easily accessible compared with PHCs.

Almost one-fourth of the respondents surveyed had used the facility of PHCs. Amongst them almost all of them were satisfied with the physical and medical services of the centres. Mandla and Balaghat respondents were also relatively more satisfied with the services. Availability of doctors, doctor's care for the patients.

Doctors attending PHCs regularly are some of the areas of concern. In sidhi and Tikamgarh doctors care was perceived to be worst. In these two districts even the paramedical staff attending PHCs regularly was perceived to be relatively worst.

3.4. Beneficiary Perception of the Functioning of PHCs

Table 3.4. Perception of Beneficiaries using Primary Health Centres

| Percentage of Satisfied Respondents in Districts Visited | | | | | | | | | |
|--|------------------------------------|----------|--------|-------|------|--------|--------|-------|-----------|
| S.N. | Nature of Perception | Balaghat | Bhopal | Dewas | Dhar | Mandla | Morena | Sidhi | Tikamgarh |
| 1 | Satisfied with health facilities | 14 | 13 | 9 | 14 | 16 | 16 | 18 | 17 |
| 2 | Satisfied with infrastructure | 14 | 13 | 9 | 14 | 14 | 16 | 18 | 13 |
| 3 | Doctors are available | 14 | 13 | 9 | 14 | 15 | 16 | 18 | 13 |
| 4 | Doctors attend regularly | 11 | 13 | 12 | 12 | 15 | 15 | 12 | 10 |
| 5 | Doctors care for the patients | 11 | 13 | 12 | 15 | 16 | 15 | 12 | 9 |
| 6 | Paramedical staff are adequate | 11 | 13 | 12 | 12 | 14 | 15 | 12 | 11 |
| 7 | Paramedical staff attend regularly | 10 | 13 | 12 | 15 | 16 | 15 | 12 | 8 |
| Percent of Beneficiaries Surveyed who used PHCs | | 23 | 13 | 20 | 27 | 25 | 27 | 30 | 25 |

Chapter 4

Health Care by Community Health Care Centres

4.1 Introduction

The Community Health Centres (CHCs) are conceived as the first major curative health services providers addressing 80 per cent of all ailments requiring out-patient services or hospitalization. Of course, PHCs would handle all services that an MBBS doctor is qualified to provide but without the specialist support, the ability to provide care as per current norms, would be limited. Since the credibility of any health institution is generally determined by the standard of curative services it provides as benchmark to the best institutions.

The CHCs are currently provided on the population norm of 1 per 1,20,000 population in general areas and 1 per 80,000 population in tribal / desert area. By 1991 population figures there is a requirement of 5587 CHCs as against 3113 in place. Thus there is a shortfall of 2474 CHCs. Of the CHCs in place, as many as 318 do not have their own buildings. Going by the population of 2001, the requirement goes up to 6491 and the deficit increases to 3378.

The Mission attaches utmost importance to strengthening the existing CHCs and build up new ones to bring the number of CHCs broadly in conformity to the ratio of one per one lakh population. The Centre would support the entire capital expenditure for the construction of the new CHCs and the renovation of the existing CHC buildings. In some places, there are multiple health facilities being controlled by different agencies. As a result, because of the manpower and equipment shortage, none of the facilities function in an optimal manner. It would be advisable to merge these facilities at the CHC headquarters for better cohesion.

The Study Team covered one CHC in each of the 8 districts investigated. In these 8 CHCs the following respondents were covered (Table 4.1)

Table 4.1 Respondents Covered at the Community Health Centre Level

| Category of Respondents Covered | Number Covered |
|--|------------------------------|
| <u>Medical Persons</u> | |
| 1. Block Medical Officers | 10 |
| 2. Lady Doctor | 5 |
| 3. Pediatrician | 1 |
| 4. Staff Nurse | 11 |
| 5. Dietician | 1 |
| 6. Multipurpose Worker | 1 |
| <u>Non Medical Persons</u> | |
| 7. Elected Representatives | 4 |
| 8. CEO, Janpad | 2 |
| 9. Block Programme Managers | 8 |
| 10. Beneficiaries | 55 |
| 11. Others | 5 |
| Total | ----- 103 ----- |

4.2.1 Review of Service Delivery at CHC Level

Although CHCs are visualized as the first curative health service providers, most of the services provided related to ANC, PNC and child health care including immunization. This is because in most CHCs, there are no specialist services at CHC level. Any chronic disease case reported at CHC level is being referred to District Hospital.

Most of the rural women, particularly the illiterate and poor are availing ANC services from public health institutions. All the CHCs surveyed have referral linked Janani Express Transport Services. In promoting ANC services, ASHAs have significant impact and influence. Women from rural areas are increasingly resorting to institutional deliveries, due to counseling by ASHAs and most of the deliveries have been normal deliveries, because facilities for caesarean operations are practically absent. In two CHCs there were lady surgeons but due to lack of anesthetic services, the lady surgeons are not able to offer caesarian services. Increasing tendency to utilize institutional delivery facilities has reduced maternal mortality and foetal losses. However facilities for institutional deliveries are being maintained very poorly. Only 2 of the 8 CHCs surveyed have been maintaining hygiene and sanitation in and around operation theatres (OTs) and labour rooms. In the other six the OTs and labour rooms are not fit to be used even as store rooms. They are not cleaned and the equipment is non functional.

Most of the women seem to be neglecting postnatal care. All the same, in households where ASHAs make regular visits there is a greater appreciation of the need to postnatal care facilities from public health care institutions.

Child health care package in the public health institutions comprises of

- new born-home and institutions based – care;
- proper counseling of mothers on child care including breast feeding;
- food supplementation; and
- a complete package of immunization programme for protection of children from life threatening and preventable diseases

These services have been observed to be good and have caused reduction in post neonatal infant mortality. Immunization has been covering children from 1 to 5 years of age. For dropouts from immunization, as stated earlier, Defaulter Tracking System (innovated by the UNICEF) is being implemented with immense positive outcome.

4.3 Infrastructure Support at the CHC Level

Emergency services for sick children have been observed to be there in all the 8 CHCs, although only one CHC had a paediatrician. Bed occupancy is very satisfactory as there are 24 hours health care facilities in all the CHCs.

Overall Balaghat followed by Bhopal district CHCs had better infrastructural support among the eight districts. Such support is relatively inadequate in Morena, Sidhi and Tikamgarh. With respect to specific services, Gynecology / Obstetric facility was available only in three CHCs. Safer abortion facility, emergency obstetric care, availability of ECG and x-ray facility was available in only two CHCs and ultrasound facility in one of the CHCs. Hygiene of CHCs with respect to conditions of floors, OPD, OT was also an area of concern for five CHCs. (Table 4.2).

Table 4.2 Health Infrastructure support in the Selected Districts of M.P. 2012

| Category of Infrastructure Support | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|--|---|---|---|---|---|---|---|---|
| 24-hour services | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Emergency obstetric care | - | 1 | - | 1 | - | - | - | - |
| Emergency of sick children | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Full range of family planning services | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Safe abortion services | - | 1 | - | 1 | - | - | - | - |
| Treatment of STI/RTI | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Referral Transport services | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Separate Wards for Male/Female | - | - | - | - | - | - | - | - |
| Paediatric beds | - | - | - | - | - | - | - | - |
| Counseling for HIV/AIDS/STD | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Ante Natal Care | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Postnatal care | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Immunization services | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Gynecology / Obstetrics | 1 | - | 1 | 1 | - | - | - | - |
| Rogi kalian samiti | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Availability of ECG | 1 | - | - | 1 | - | - | - | - |
| Ultrasound | 1 | - | - | - | - | - | - | - |
| Availability of specific lab tests | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Own building | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Good condition of floors | - | 1 | 1 | 1 | - | - | - | - |
| Good / clean OPD | 1 | 1 | 1 | 1 | - | - | - | - |
| Good / clean OT | - | 1 | 1 | 1 | - | - | - | - |
| Separate Toilets for Males/Females | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Pharmacy | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Functional Labour Room | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| X-Ray facilities | - | 1 | - | 1 | - | - | - | - |
| Operation Theatre | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

‘1’ indicates availability

District Codes: 1 Balaghat 2 Bhopal 3 Dewas 4 Dhar 5 Mandla
6 Morena 7 Siddhi 8 Tikamgarh

4.4 Human Resource Support

Data on human resource support at CHC level could be obtained only respect of 3 districts: Balaghat, Dewas and Dhar. Other districts have not responded despite repeated reminders. As per available data, medical personnel in position are far less than the number sanctioned. Also, existing staff are far less than the norms specified by the NRHM. Non-medical staff at CHC level also is far higher than the paramedical staff. For providing curative health services, paramedical staff are essential, so that medical staff like physicians and other specialists have adequate support. With the available human resource support, curative health care cannot be effective at CHC level. Maternity and Child health care services, as a referral service have been satisfactory and they dominated the spectrum of services provided at CHC level.

The study revealed that, at this level, while both the General Body and Executive Committee of have high powered bodies with wide ranging powers and functions, non-medical members, particularly the bureaucrats and elected representatives of Janpad Panchayat have been taking RKS very casually. CEOs of Janpad Panchayat interviewed have not yet realized that monitoring and supervision of health care faculties within their geographical jurisdiction is their responsibility and not of the Block Medical Officer (BMO) concerned. The non-medical members have been attending the meetings of RKS as a matter of formality. They neither take interest in the preparation of agenda for RKS meetings nor in the decision taken there in. This goes against the spirit of the National Health Policy, 2001 which emphasized implementation of public health programmes through local self-government institutions. The Task Force appointed by the Planning Commission, Government of India to review involvement of PRIs in rural health care delivery proposed activities of PRIs related to identification of people in need of health care services: monitoring village health workers performance, and primary and secondary health care facilities. The present attitude of PRIs and its bureaucrats and elected representatives clearly bring out that the PRIs are not equipped to take up the kind of activities proposed for them by the Task Force.

4.5 Beneficiaries Perception of the Functioning of CHCs

A low percentage of beneficiaries were using the services of CHCs (Table 4.3) during the last one year. Beneficiaries using the services were by and large dissatisfied with the services. The dissatisfaction level was much higher in Bhopal, Balaghat, Morena, Sidhi and Dhar CHCs on all the parameters. Availability of doctors is a major issue in most of the districts, though relatively better in Dewas and Tikamgarh. Doctor care was equally badly perceived in most of the CHCs.

Table 4.3 Beneficiary Perception of Services at CHC

| Nature of Perception | Balaghat | Bhopal | Dewas | Dhar | Mandla | Morena | Siddhi | Tikamgarh |
|---|----------|--------|-------|------|--------|--------|--------|-----------|
| Satisfied with health facilities | 5 | 11 | 15 | 8 | 16 | 5 | 8 | 18 |
| Satisfied with infrastructure | 5 | 11 | 15 | 8 | 7 | 5 | 8 | 13 |
| Paramedical staff are adequate | 3 | 11 | 19 | 8 | 11 | 4 | 5 | 12 |
| Paramedical staff attend regularly | 5 | 11 | 15 | 8 | 16 | 4 | 5 | 9 |
| Doctors are available | 3 | 7 | 15 | 8 | 8 | 5 | 8 | 13 |
| Doctors care for the patients and do not discriminate | 3 | 7 | 15 | 8 | 9 | 4 | 5 | 10 |
| Percentage beneficiaries using CHCs | 19 | 33 | 36 | 23 | 25 | 19 | 25 | 33 |

4.6 The study found that although CHCs are visualized as the first curative health provider, most of the services provided by CHC related to ANC, PNC and child health care including immunization.

Only two CHCs are observed to be having emergency obstetric care. In other CHCs obstetric care facilities are missing as there are no lady doctors. Bed occupancy in the patient ward, has been good, as there are 24-hour health care facilities in all the CHCs. Specific lab-test facilities are there at every CHC with a trained technician, and adequate equipment and chemicals.

Human resource support provided is less than the sanctioned positions. Even the sanctioned positions are less than the norms specified by NRHM, particularly in respect of specialists. Health Care can not, therefore, be effective at CHC level.

Although both the general Body and the Executive Committee of RKS have wide powers and well defined functions, non-medical members, particularly the bureaucrats and elected representatives of Janpad Panchayat have a very casual attitude towards RKS. These persons are yet to realize that planning, monitoring and supervision of health care facilities within their geographical jurisdiction is their responsibility. General feeling is that health care at dispensaries, hospitals and RKS are the responsibility of the health department. Non medical members of RKS have been attending its meetings as a matter of formality. They did not show interest in either the agenda for RKS meetings or in the decisions taken therein. This goes against the spirit of National Health Policy 2011 which emphasized implementation of Public Health Programmes through local self-government institutions.

Beneficiaries were not satisfied with the services provided by CHCs.

Chapter 5

Health Care by the District Health Mission

As part of the NRHM strategy, it is required to develop a health management team with a strong District Health Mission with multifarious roles (Annexure.)

The Study covered Districts Health Mission in each of the eight districts surveyed with the following respondents (Table 5.1)

Table 5.1 Respondents covered at the District Health Mission Level

| SL.NO. | CATEGORY OF RESPONDENTS COVERED | NUMBERS COVERED |
|--------|--|-----------------|
| 1 | Chief Medical and Health Officer (CMHO) | 8 |
| 2 | District Project Manager (DPM) | 6 |
| 3 | Civil Surgeon | 4 |
| 4 | Staff Nurse | 15 |
| 5 | Medical Officer | 6 |
| 6 | Paediatrician | 1 |
| 7 | Dental Surgeon | 1 |
| 8 | Lady Surgeon | 1 |
| 9 | Ophthalmologist | 1 |
| 10 | Dietician | 5 |
| 11 | Malaria Consultant | 1 |
| 12 | Unesco Consultant | 3 |
| 13 | District Monitoring and Evaluation Officer | 1 |
| 14 | Assistant Statistical Officer | 3 |
| | Total :- | 56 |

5.2 Disease Pattern of Districts Surveyed

Although data on number of persons reporting sick by disease is generated at the Sub-centre level, it is available in an aggregated form only at the district level (See Table 5.2).

The data shows that major diseases in all the eight districts were: Acute Respiratory Infection, Acute Diarrheal, Bacillary, Malaria and Fever of unknown origin. Malaria is high in Morena and Tikamgarh districts which are both dust prone and backward districts. Bhopal, the capital city of Madhya Pradesh, with better access to medical facilities, is dominated by patients with diseases like Measles, Diphtheria, and viral hepatitis.

One major concern is the dog and snake bites for which there are no facilities for primary care at a sub-centre where such cases occur. The patients have to travel to CHC or district hospitals for treatment. Interestingly tuberculosis HIV/AIDS and Heart Diseases are not of major concern.

Table 5.2 Number of Person Reporting Sick by Disease in the District as a whole in 2010-2011

| SN. | NAME OF DISEASE | DISTRICTS | | | | | | | | TOTAL |
|-----|--|-----------|--------|-------|-------|--------|--------|-------|------------|-------|
| | | BALA GHAT | BHOPAL | DEWAS | DHAR | MANDLA | MORENA | SIDHI | TIKAM GARH | |
| 1 | Malaria | 702 | 434 | 1373 | 2641 | 193 | 24621 | 1280 | 38437 | |
| 2 | Measles | 0 | 23840 | 0 | 12 | 12 | 23 | 26 | 2 | |
| 3 | Chicken Pox | 0 | 0 | 3 | 7 | 0 | 3 | 0 | 0 | |
| 4 | Dengue/DHF/DSS | 0 | 0 | 0 | 0 | 359 | 0 | 0 | 582 | |
| 5 | Chikungunya | 0 | 0 | 0 | 3 | 0 | 48 | 82 | 0 | |
| 6 | Meningitis | 4 | 0 | 0 | 0 | 0 | 52 | 0 | 2 | |
| 7 | Acute Encephalitis Syndrome | 3 | 6 | 0 | 0 | 0 | 296 | 19 | 1 | |
| 8 | Enteric Fever | 1557 | | 1235 | 4999 | 0 | 14956 | 32 | 1013 | |
| 9 | Fever of Unknown Origin (PUO) | 9659 | 1 | 12524 | 45003 | 11 | 28401 | 531 | 36358 | |
| 10 | Diphtheria | 0 | 131690 | 0 | 0 | 9 | 0 | 41 | 0 | |
| 11 | Pertussia | 0 | 505 | 23 | 0 | 0 | 0 | 20 | 0 | |
| 12 | Tuberculosis | 17 | 215 | - | - | 17 | 26 | 12 | - | |
| 13 | Acute Respiratory Infection (ARI) other than interventions | 3646 | 6803 | 18672 | 30096 | 48 | 32585 | 147 | 11863 | |
| 14 | Pneumonia | 204 | 16 | 53 | 926 | 64 | 2402 | 92 | 291 | |
| 15 | Acute Diarrhoeal Disease (including acutegastroenteritis) | 1651 | 52 | 3737 | 9924 | 4325 | 17796 | 134 | 26520 | |
| 16 | Bacillary | 845 | 4082 | 40 | 2603 | - | 2177 | 53 | 414 | |
| 17 | Viral Hepatitis | 39 | 54500 | 106 | 40 | - | 502 | 4 | 122 | |
| 18 | Leptospirosis | 0 | 0 | 0 | 0 | - | 24 | 0 | 4 | |
| 19 | Acute Flaccid Paralysis (<15 years of Age) | 1 | 0 | 0 | 17 | - | 35 | 1 | 10 | |

| SN. | NAME OF DISEASE | DISTRICTS | | | | | | | | TOTAL |
|-----|--|-----------|---------|--------|--------|--------|--------|--------|------------|-------|
| | | BALA GHAT | BHOPAL | DEWAS | DHAR | MANDLA | MORENA | SIDHI | TIKAM GARH | |
| 20 | Any other State Specific Disease | 1531 | 28 | 0 | 70 | - | 13525 | 9 | 0 | |
| 21 | Unusual Syndromes NOT captured above (specify clinical diagnosis) | 1958 | 0 | 0 | 313 | - | 4687 | 327 | 0 | |
| 22 | Total New OPD attendance (Not to be filled up when data collected for indoor cases) | 108478 | 1457876 | 124697 | 358435 | 304785 | 427767 | 138812 | 229539 | |
| 23 | Action taken in brief if unusual increase notice in cases/deaths for any of the above diseases | 28 | - | 0 | 0 | 0 | 0 | 3019 | 4063 | |
| 24 | Dog bite | 243 | 2 | 506 | 1797 | 35 | 2461 | 869 | 1176 | |
| 25 | Snake bite | 58 | - | 1 | 26 | 0 | 7 | 654 | 52 | |
| 26 | HIV/AIDS | 1 | 0 | - | - | 0 | 1 | 4 | - | |
| 27 | Heart Diseases | 123 | 1032 | - | - | 59 | 150 | 0 | - | |
| 28 | Leprosy | - | - | - | - | - | - | 5 | - | |

Source : Health & Family Welfare Report – Government of Madhya Pradesh.

5.3 Review of Service Delivery at District Hospital Level

Vertical Integration of all Health Societies created under different programmes in the districts into District Health Society (DHS) has been observed only in 5 districts out of the eight surveyed i.e., Bhopal, Balaghat, Dhar, Mandla and Sidhi (Table 5.2).

As observed under section 5.2 incidence of diseases, under the National Disease Control Programmes (NDCP), like tuberculosis, HIV/AIDS and leprosy was quite scanty, excepting Malaria. Apparently, NCDPs with a separate specific head under NRHM budget are working very well. In this respect, Dewas, Dhar and Tikamgarh districts are doing exceedingly well (Table 5.2 and 5.3).

Table 5.3 . Status of District Level Functioning of Public Health Institution in M.P. 2012

| SN. | TYPE OF FUNCTION | NUMBER OF DISTRICTS OBSERVED TO BE DISCHARGING THE FUNCTIONS |
|-----|---|--|
| | Number of Districts Surveyed - 8 | |
| 1 | Vertical Health Societies Merged under DHS | 8 |
| 2 | Districts who have prepared District Annual Health Plans | 5 |
| 3 | Funds Transfer Electronically by State to District | 8 |
| 4 | Discussions on PHC Health Committee Reports | - |
| 5 | Monthly Monitoring of infrastructure provided under NRHM | 3 |
| 6 | Initiative in Identification of problems faced by patients at various level | 1 |
| 7 | NGOs involvement in the Mission at District Level | 1 |
| 8 | Converged with other Departments of the Government | - |
| 9 | Waiting Space adjacent to consultation and treatment | 8 |
| 10 | Registration counter | 8 |
| 11 | Doctors Duty Room | 8 |
| 12 | Pharmacy | 8 |
| 13 | ICU | 2 |
| 14 | 24 Hours water supply | 7 |
| 15 | Proper Drainage and Sanitation System | 4 |
| 16 | Parking facilities | 8 |
| 17 | Telephone facility | 8 |

Intensive care units (ICUs) were observed to be available in two districts i.e., Dewas and Dhar. Monthly monitoring of infrastructure facilities provided was observed in 3 districts Dewas, Dhar and Mandla. NGOs involvement in the District Mission was observed only in Dhar district. Proper drainage and sanitation system was found functioning in all the district hospitals. Pharmacy is available in all the District Hospitals.

5.4 Human Resource Support

Despite concerted efforts data on human resources support could be obtained only in respect of 7 of the 8 districts surveyed: Balaghat, Dewas, Dhar, Mandla, Morena, Sidhi and Tikamgarh (Table 5.4). As can be seen from Table 5.4, in the case of most of the categories of manpower sanctioned positions have not been filled up. Balaghat had the maximum shortage of specialists compared to the sanctioned strength in Dhar and Morena districts, less than half of the medical officers were in position compared to the sanctioned strength.

Table 5.4 Human Resource at District Level

| S.N. | Category of Medical Manpower | Balaghat | | Bhopal | | Dewas | | Dhar | | Mandla | | Morena | | Sidhi | | Tikamgarh | |
|------|------------------------------|----------|-----|--------|---|-------|----|------|----|--------|-----|--------|-----|-------|-----|-----------|----|
| | | S | P | S | P | S | P | S | P | S | P | S | P | S | P | S | P |
| 1 | Specialists | | | | | | | | | | | | | | | | |
| | a. Obst-gynae | 9 | - | | | 11 | 2 | 14 | 3 | 3 | 1 | 14 | 3 | 7 | 3 | 9 | 1 |
| | b. Pediathician | 4 | - | | | 9 | 6 | 1 | - | 3 | 2 | 1 | 0 | 2 | 1 | 9 | 2 |
| | c. Anesthetist | 4 | - | | | 6 | 2 | 3 | 1 | 3 | 1 | 3 | 1 | - | - | 9 | 2 |
| | d. Surgeon | 12 | - | | | 11 | 6 | 8 | 2 | 11 | 2 | 8 | 2 | 16 | 15 | 7 | 2 |
| | e. Orthopaedician | - | - | | | 1 | 1 | 3 | 2 | 2 | 2 | 3 | 2 | - | - | 2 | 1 |
| | f. Ophthalmology | - | - | | | 3 | 1 | 4 | 1 | 2 | 1 | 4 | 1 | - | - | 1 | 1 |
| | g. Tuberculosis | - | - | | | 1 | - | 4 | 2 | 1 | 1 | 4 | 2 | - | - | 1 | 0 |
| | h. Demitology | - | - | | | 12 | 5 | 1 | 1 | - | - | 1 | 1 | - | - | 1 | 0 |
| | i. Physician | 9 | - | | | 63 | 37 | 14 | 3 | - | - | 14 | 3 | 22 | 21 | 5 | 3 |
| 2 | Medical Officers | 23 | 14 | | | 61 | 46 | 22 | 8 | 13 | 9 | 22 | 8 | 30 | 25 | 33 | 15 |
| 3 | AYUSH Doctors | 10 | | | | 7 | - | 4 | 3 | 1 | 1 | 4 | 4 | 5 | 5 | 1 | 1 |
| 4 | Staff Nurses | 42 | 35 | | | 78 | 27 | 19 | 3 | 26 | 2 | 4 | 3 | 38 | 24 | 38 | 23 |
| 5 | ANMS | 37 | 35 | | | 53 | 37 | 100 | 32 | 55 | 5 | 19 | 3 | 28 | 27 | 89 | 71 |
| 6 | Lab Technicians | 21 | 9 | | | 63 | 34 | 12 | 8 | 6 | 6 | 100 | 32 | 7 | 6 | 14 | 8 |
| 7 | Pharmacists | 16 | 0.2 | | | 21 | 26 | 12 | 5 | 6 | 6 | 4 | 3 | 7 | 6 | 12 | 12 |
| 8 | Malaria Officers | | | | | - | - | 1 | 1 | - | - | 12 | 8 | - | - | - | - |
| 9 | ASHAS | | | | | 13 | 10 | - | - | - | - | 12 | 5 | 15 | 9 | - | - |
| 10 | Other Paramedical | 80 | 65 | | | 58 | 37 | 30 | 25 | - | - | 30 | 26 | 35 | 24 | 92 | 70 |
| 11 | Non-Medical Staff | 120 | 120 | | | 87 | 61 | 176 | 20 | 621 | 438 | 181 | 129 | 192 | 190 | 64 | 51 |

S = Sanctioned; P = In Position;

A review of finding shows that District Hospitals are primarily being used for delivery care and child health care. This is because service delivery at Sub-Centre, PHC and CHC levels in many cases has not been upto the mark in the perception of beneficiaries. As a result, treatment and care of patients with chronic and common ailments are adversely affected. This trend needs to be changed.

District Health Societies (DHS) have been functioning well. The study team had the opportunity to attend monthly monitoring meetings of DHSs in two districts, chaired by the respective District Collectors along with the CEO of Zila Parishads. The meetings reviewed health status based on the reports of Rogi Kalyan Samitis (RKSS) at CHC and PHC level; and remedial measures were suggested.

Vertical integration of all the Health Societies has been reported in 5 districts. Incidence of diseases under the National Disease Control Programmes (NDCP) excepting Malaria, has been very scanty. Apparently, NDCPs with a separate specific head, under NRHM budget are working very well. Interestingly, the tribal districts and backward districts are doing very well in this regard.

Overall availability of basic infrastructural facilities like Blood Storage facility, proper sanitation, doctors' room, pharmacy, telephone, and fax machines are available in most of district hospitals. However ICU facility was observed to be there in only two districts. NGOs involvement in health care and safety needs to be improved. 24 hours water supply was observed in only 7 out of the eight districts surveyed. In respect of most categories of manpower sanctioned positions have not been filled up in 7 districts for which data could be obtained (Table 5.4).

Zila Panchayats have been vested with vast powers and functions without any ambiguity. Adequate care has been taken to make budget provision to incur expenditure in the discharge of functions relating to ANC, PNC and child health care including immunization. As a result, treatment and care of patients with chronic diseases endemic diseases and common ailments like Malaria, Acute Respiratory infection other than tuberculosis, enteric fever and fever of unknown origin are adversely affected.

Chapter 6

A Model Structure of Rural Health Care Services within the Framework of Panchayati Raj System

6.1 Introduction

“Today the single most important reason for rural area indebtedness is expenditure on health¹⁵. This is because rural health care at all levels starting from sub-centre to District Hospital is over burdened by services like ANC, PNC, and child health care and supplementary nutrition. In the words of union Rural Development Minister, Shri Jairam Ramesh public health system (PHS) in the country has “collapsed”. PHS includes rural health care services as well¹⁶.

6.2 Reasons for the Poor Performance of NRHM

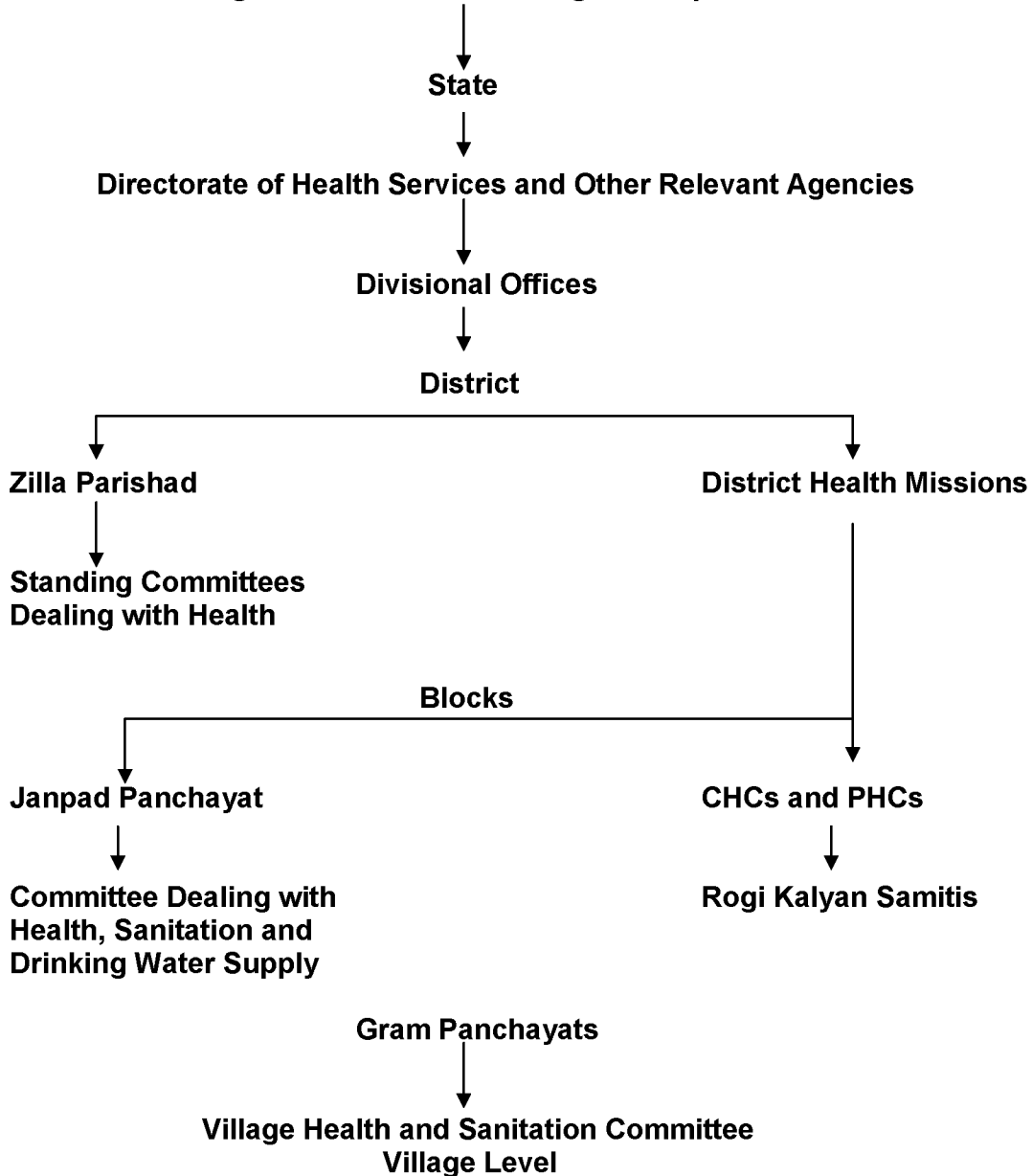
- a) vacant positions of specialists, doctors and paramedical staff
- b) inadequate attention to capacity building of medical and paramedical staff
- c) insufficient infrastructure and staff shortages at sub centres (SC) and primary health centres (PHC) are hindering outreach of health services in rural areas. It was observed that many PHCs do not have a qualified doctor. Block Medical Officer at Community Health Centre (CHC) visits PHCs without doctor on alternative days. Therefore, delivery of services like ANC, PHC and Child health care including immunization and supplementary nutrition are adversely affected. As a result, the concerned persons are flocking to district hospitals and are over crowding them
- d) AYUSH doctors were seen only at two places: one was a CHC and the other was a PHC. In other CHCs and PHCs visited there were no AYUSH doctors.

15 “public health system has collapsed, says Jairam”, Times of India, November 17, 2012, New Delhi edition, p.9

16 “Times of India, ibid. p.9

- e) Through discussions with beneficiaries, study team observed that some times spurious and outdated drugs and medicines are being supplied. Hence, procurement and supply of drugs needs immediate attention to improve quality of health care services;
- f) Accountability in delivery of health care services at SC and PHC level is very low. Financial Accountability in the Utilization of untied funds, maintenance grants and RKS grants is very poor. In particular as reported by the beneficiaries, there is rampant misuse of annual grant of untied funds of about Rs.10,000/- for maintenance of cleanliness and sanitation within the villages under the sub centre;
- g) ASHA's mentoring and retraining for updating and upgrading skills is a neglected area. This is hampering optimal utilization of existing health care facilities and services;
- h) Grievance redressal mechanism for health care users is a neglected area;
- i) Monitoring and supervision is generally lacking. In particular, monitoring maintenance of infrastructural facilities/equipment provided to SCs, PHCs and CHCs is a neglected area. In patient wards at many PHCs need considerable improvement. Operation theaters at some of CHCs are just dumping grounds for waste material of the CHC
- j) Partnerships with non government organization (NGOs) is critical for the success of NRHM, as they have
 - a role in advocacy for a right of health care by promoting effective community action; and
 - service delivery through many good hospitals run by trust managed by NGOs
 - partnership with NGOs is a neglected area in M.P.

6.3 Existing Structure for Monitoring and Supervision



In the existing structure Joint Director and his staff at Divisional Offices monitor and supervise progress at District Health Mission. Chief Health and Medical Officer at the health mission, in turn monitors and supervises health care services and infrastructure facilities at CHC level. Block Medical Officer at CHC undertakes monitoring and supervision of PHCs. Medical officer at PHC is charged with the responsibility of monitoring and supervision of services and infrastructure at sub centres. Although, there is a system in place for proper monitoring and

supervision of health care services delivered and upkeep of infrastructure facilities provided, many deficiencies and lacunae were noticed such as those illustrated in section 2. There is, therefore, a need to restructure monitoring and supervision of infrastructure and human resource structures.

6.4 Alternative Model for Monitoring and Supervision of Health Care Facilities:

The alternative model will have the following objectives:

- To enable community and community based organizations to provide feed back on community health needs, community entitlements, functioning of various levels of the public health system and service providers; and to identify gaps, deficiencies and levels of community satisfaction in such a way that it can facilitate corrective action in a framework of accountability.
- To promote partnership with non-government health care providers through better regulation and transparent system of accreditation for quality health services at agreed costs and norms. There are many trusts and society managed hospitals and dispensaries and accredited medical practitioners to enhance utilization of public owned health facilities
- To restructure deployment of doctors, and staff nurses and other paramedical staff in order to ensure optimum OPD attendance and service provisions to meet the public health goals under NRHM.
- To establish accountable and effective implementation arrangements with clarity regarding tasks, teams roles, functions, powers at all levels of the NRHM system.

These objectives call for actions on the following lines:

- Empowerment of Panchayat Raj Institutions with assured availability of funds, clear articulation of functions and transfer of appropriate combination of functionaries to discharge the functions set out.
- Enlist support of Non-Government Organizations (NGOs) in
 - building up awareness about the facilities available under the public health care system and mobilizing people to access the facilities
 - encouraging transparency and accountability in the health sector by activating groups of people like women groups (Mahila Mandals), self help groups and youth

clubs to provide regular feed back on existing care facilities and extent of attention that the poor receive from the health services

- extending support to capacity building among the PRI members and members of village health and sanitation committees (VHSCs) in efficiently handling health development related functions;
 - aiding the sub centres (SCs) PHC and CHG in decentralized participation planning, implementation, monitoring and, inter sectoral convergence and community ownership of the approved schemes in health development;
 - facilitating discussions on such issues as nutrition, sanitation, preventive health care and safe drinking water in Gram Sabhas through active participation of all members; and
 - providing an independent assessment of public health care facilities to facilitate better standards and regulation in health care delivery.
- Standardization of Quality health services
 - Establishment of standard treatment protocols for local disease pattern identified through disease surveillance
 - Encouraging preparation of reports at all levels like SC, PHC CHC and district level on health status of people and local disease patterns. At present such reports are being made only at district level, although relevant data is being generated at all levels.
 - Enforcing discipline, responsibility and accountabilities in the procurement and distribution of medicines, and in maintaining the equipment and infrastructure provided to conform to high standards.

6.5 Allocation of Tasks to Each Level

- a) At the Village level ASHA is the link between rural communities and the public health system. In that, ASHA would reinforce community action for universal immunization, safe delivery, new born care, prevention of water-borne and other communicable diseases, nutrition and sanitation. ASHA will assist the villagers in referral services and provide information on the treatments of various diseases within the district.
- b) At the Sub Centre Levels, there should be two ANMs: one to be stationed at the head quarters of SC all the time and other to be mobile for supervising the activities of ASHA and Anganwadi Workers (AWWs) at the villages under the SC. The SC building

will also be the nodal centre for all villagers for dispensing out patient (OP) services by visiting allopathic/AYUSH doctors at least thrice a week.

- c) Village Health and Sanitation Committees (VHSCs) at SC level should monitor health programmes of SC, and execute sanitation drinking water programmes. Its activities should be subject to financial, performance and social audits*. VHSC should prepare plans for health in the villages under the Gram Panchayat (GP), and should facilitate convergence with other

departments at the village level. In this regard VHSCc may seek the help of local NGOs, accredited by the PRIs, to build up awareness among villagers about health care and sanitation, and about the need to access existing public health care facilities and make optimum use of the same; and building up capacities of VHSc members in health and sanitation planning and implementation of schemes approved.

- d) At the PHC level it is expected that the most effective intervention to achieve significant improvements in the health status of population in the locality would be possible. Unfortunately, the ground level situation is very different. Many PHCs do not even have a single doctor; although each PHC is supposed to have two doctors; one allopathy doctor and one AYUSH doctor. Further each PHC has a Rogi Kalyan Samiti (RKS) to monitor health care services and oversee implementation of schemes approved for health development. At present, PHCs are being used exclusively for antenatal, postnatal and children immunization services. Very little is being done to extend primary care to control locally prevalent diseases and chronic diseases. RKS also is not focusing on health care. Most of the discussions in RKS centred around repair and maintenance of buildings and furniture. RKS, on the other hand, should focus on quality of services rendered by PHC in improving the health status of local people, in performing key diagnostic tests, and in serving as a key point for national health programmes. RKS should also review the health development plans prepared by VHSCs under its jurisdiction and integrate them into PHC/cluster level health development plans and annual action plans. In addition, PHC should;

- a) coordinate with local community based organizations (CBO's) and NGOs to improve the status of local people.
- b) review the functioning of sub centres under PHC's jurisdiction and take appropriate action in consultation with the CHC concerned to improve the functioning of sub centers.

- c) CHCs are first major hospital services under the structure of NRHM addressing 80 percent of all local ailments requiring out patient (OP) or in patient (IP) facilities. Positioning of all relevant specialists comprising surgeons, gynecologists, paediatricians, and anesthetists is essential. In addition, periodic and regular visits specialists such as ophthalmologists, dermatologists, and tuberculosis specialists and dental surgeons should be facilitated. Further, CHCs should have teams of medical officers to visit PHCs and SCs on a regular basis in order to review and improve primary health care of patients at PHC/SC itself. This will give immediate relief to patients with chronic diseases and also improve the confidence of the rural people in the public health system. CHC should attempt to fill vacant positions of medical officers, staff nurses and other para medical staff through contractual appointments, in consultation with the chief health and medical officer of the district and CEO of the Janpad Panchayat concerned, of local accredited health practitioners and paramedical staff and also attune them to the functioning of NRHM through training. Regular supervision and maintenance of equipment and vehicles, and cleanliness provided at CHC, PHCs and SCs should also be the responsibility of CHC. Again with the approval of the chief health and medical officer of the district and the CEO of the Janpad Panchayat the CHC should out source maintenance of buildings and equipment, referral transport services, cleaning, catering services and waste management in order to reduce workload on regular health officials and to bring about improvements in the Quality of health services at CHCs, PHCs and SCs. Roji Kalyan Samitis (RKS) at CHC/PHC level should be reconstituted to comprise of users including members of PRIs, local NGOs, CBOs and health professionals in order to facilitate community ownership of CHC/PHC.
- d) District Health Mission (DHM) has a crucial role in decentralized health planning, implementing, monitoring and evaluating progress; in review of PHC and CHC health committee reports; and integration of PHC and CHC level health plans into district plan. In addition, DHM should actively participate in performance audit including performance quality of equipment and infrastructure facilities provided and in social audit of health care services delivered at District Hospital, CHC PHC and SC levels.

Further, lot more needs to be done by DHMs in involving NGOs and CBOs in health planning, implementation, monitoring and evaluation. Financial Audit in any case will be undertaken by the State/Central Governments. In addition, DHMs should engage external auditors to perform internal audit so that it would facilitate smooth audit by the State/Central Governments. DHM should provide leadership and support to CHG, PHG and SCs in contractual employment of health professionals and paramedical staff with skills that the system does not have, in outsourcing cleanliness, repairs and audiences and waste management activities.

- e) At the Divisional Level the following activities need to be under taken:-
- Accounts and Finance Management
 - Human Resource Planning and Development
 - Procurement, Storage and Logistics of medicines and equipment as per approved procedures by the State/Central Governments
 - Administration and Planning
 - Infrastructure and Equipment Development and Reviewing their Maintenance
 - Maintaining teams for performance audit and social audit at Divisional and District Levels.
 - Improving Association with PRIs, NGOs and CBOs and coordinating their active involvement health planning and implementation, monitoring and evaluation
 - Reviewing the functioning of District Hospitals, CHCs, PHCs and SCs and initiating appropriate corrective action at the concerned levels
 - Establish Resource Group for Professionals through initiating action for filling up of vacant positions and for contractual employment of professionals and paramedical staff with skills which the system, under the jurisdiction of the Division, doest not have.
 - Provide data analysis and compilation facility in order to prepare regular health management information system (HMIS) reports at DHM, CHC, PHC and SC levels.

6.6 In Summary the following may be noted

- a) In the proposed alternative model SCs and PHCs will focus establishing firm linkages with rural population at the grass root level to build up awareness about public health facilities and to improve their access to public health institutions. This is in addition to their basic function of providing primary health care and facilitating out reach to higher level public health institutions through optimal use of referral transport system.
- b) CHCs will provide hospitalization services to all those who require OPD and IPD facilities. CHC will, in coordination with DHM, attempt to fill vacancies of all medical officers, staff nurses and other paramedical staff through contractual appointment of local accredited health professionals with the skills that the grass root level (CHC, PHC & SC) system does not have. This is to ensure that each PHC has at least one medical officer and a staff nurse; and the CHC should have teams of medical officers to facilitate regular and periodic visits at least thrice a week to each sub centre. CHC should also outsource maintenance of equipment and vehicles provided; and cleanliness, catering and waste management services in order to reduce workload on regular health officials and to bring about improvements in the quality of health services at CHC, PHC and SC levels. RAs and CHC and PHC levels should be restructured to comprise largely of users to facilitate community ownership of CHCs, PHCs and SCs.
- c) District Health Mission (DHMs) have a pivotal role in decentralized planning, implementation and monitoring and evaluating progress of health development. DHM should out source to external auditors internal financial audit of DHM, CHC, PHC and SC. DHM should also assist the divisional office in regular and periodic performance audit and social audit of the quality and extent of coverage of public health facilities under NRHM.
- d) Divisional level can play a crucial role by undertaking the following activities
 - * Accounts and financial management
 - * Procurement, storage and logistics of medicines and equipment
 - * Administration and planning
 - * Infrastructure and equipment development and reviewing their maintenance
 - * Improving association of NGOs and CBOs and coordinating their active involvement in planning, implementation, and monitoring and evaluation of health development for poor in particular

- * Reviewing the functioning of District Hospitals, CHCs, PHCs and SCs through regular and periodic performance and social audits, and initiating appropriate and timely corrective action at the concerned levels.
- * Establishing resource group of professionals in all the relevant specialization and ensuring their period visits district hospitals and CHCs for treatment of patients at the respective locations.

In the revised model proposed CHCs, PHCs and SCs will focus attention on providing health care, while DHMs and Divisional Offices will be vested with administration, financial management, performance management, improving association of NGOs and CBOs and extending services of specialists to District Hospitals, and CHCs and continuous improvement in the quality of health services.

Chapter 7

Success stories in providing Healthcare Facilities under NRHM

A 1.1 Introduction

In the eight districts surveyed, the Study Team covered ten sub centers (SCs), eight primary Health centers (PHCs), eight community Health Centers (CHCs) and eight district hospitals. Among these, only two success stories could be observed: one relating to Ram Nagar PHC of the Morena district and the other related to Aamjhera PHC of the Dhar district. These two PHCs have done remarkable work in soliciting public contributions through donations and in promoting Public – Private Partnership in improving the delivery of healthcare services.

A 1.2 Case of Ram Nagar PHC

Until recently Ram Nagar PHC was an SC, managed solely by an ANM assisted by ASHAs and other paramedical staff. The Gram Panchayat took active interest in improving the health services in this SC. Between Ram Nagar and Gwalior, a stretch of about eight Kilometers, there are a number of small industries. Gram Panchayat assigned to each of its elected members a group of industries so that they can establish contacts with the management of the industries assigned and solicit donations. This effort was taken seriously by all the Gram Panchayat members and vigorous efforts were made by them. These efforts resulted in donations to Ram Nagar SC which ended up in:

- upgrading the SC into PHC,
- constructing Labour Room and an in-patient ward,
- erecting a boundary wall around PHC,
- posting a medical officer to the PHC and attaching two contractual doctors, and
- facilitating regular visits by a Tuberculosis specialist, as one of the villages under a PHC has 90 % of people suffering from Tuberculosis.

All the above achievement took place because the husband of Gram Panchayat President is a learned person and has a vision for healthcare of people in the Gram Panchayat. He is also very dynamic. If he encounters any hurdles in realization of his vision, he immediately rushes to Bhopal - the state head quarters - to locate and

influence political powers that matter and then ultimately gets the work done. People of the Gram Panachayat have a high regard and respect for him. They have also been extending full cooperation to him.

Active people's support and success in resource mobilization have been the two key elements in the success of Ram Nagar PHC.

A 1.3 Case of Aamjhera PHC

Aamjhera as of now is a PHC. However, it has been approved to upgrade this PHC into a CHC by the Madhya Pradesh Government. Necessary budget has also been sanctioned for the construction of a permanent building for the CHC with all modern amenities. The medical officer at Aamjhera has already been re-designated as a Block Medical Officer (BMO). The BMO is very innovative and dynamic. With the help of Gram Panchayats covered by the PHC, the medical officer succeeded in soliciting public contribution and support for:

- establishing a separate 6 bedded male in-patient ward,
- increasing the bed strength for maternity ward from 6 to 12 with clean toilets and safe drinking water,
- constructing six bedded rooms for attendants of female patients with toilets and safe drinking water,
- setting up a private ward, with nursing home like facilities, for females who can afford to pay Rs. 100 a day,
- starting Ophthalmic and Leprosy clinics with specialist services thrice in a week,
- setting up an X-Ray clinic for use in diagnosis and treatment, and
- adding one more ambulance.

Cooperation of the gram Panchayats and public support have been the key strategies, within the approved framework, of success of the Aamjhera PHC.

The two success stories relied on:

- active participation of PRIs in improving healthcare facilities and
- soliciting public private partnership in mobilizing resources and effective public support.

These are elements of approved strategies for decentralized development within the PRS framework. Hence, they are easily replicable.

Chapter 8

A Framework for social audit of Healthcare delivery under NRHM

A 2.1 Introduction

Social audit is an audit by the society. In this the beneficiaries, people's organizations and the bureaucrats together audit the performance of healthcare programmes under NRHM. The basic objectives of social audit are:

- ensuring and encouraging peoples participation in planning, implementation, monitoring and evaluation of health care scheme;
- bringing in transparency in healthcare administration;
- providing information to the people on healthcare schemes under implementation;
- instilling responsibility of solving public grievances; and
- encouraging responsive administration by the PRIs particularly Gram Panchayats.

A 2.2 Preparation for Social Audit

Chief Executive Officer (CEO) of Janpad Panchayat selected for social audit must prepare a time table so that social audit could be conducted in all Gram Panchayats under the Janpad within one month – preferably in September / October – CEO must constitute a Social Audit Team comprising of some officials of Janpad, representatives of NGOs and CBOs, retired panchayat and health officials who served in NRHM, and prominent public personalities. Officials deputed from divisional office of NRHM and Zila Panchayat may also be associated as observers to ensure that the social audit is being done as per rules specified.

Gram Panchayat Secretary in cooperation with ANM of the sub-centre must do all preparations to conduct social audit in the presence of Public, Officials and elected members of Gram Panchayat. ANM of the sub-centre and ASHAs" of the villages concerned must be present and participate in the social audit process compulsorily.

Timetable of social audit must be given wide publicity through hand bills, notice boards as well as visual media to enable public to participate in large numbers.

A 2.3 Social Audit Model

First of all Social Audit should be conducted from the lowest to the highest level. For example, Gram Panchayat Secretary in cooperation with the ANM and the Sub-Centre must do the social audit in the presence of public. This social Audit should be conducted in the presence of elected members of the gram panchyat, ANM of the Sub-Centers and ASHAs. Gram Sabha Members should be given the right to ask any question and get any information during this audit. These reports should be presented at all the higher levels with the members of the public.

All development institutions have to be harmonized with the PRI set up. There are different possible courses of action to deal with parallel bodies. They include:

- ❖ Taking recourse to total merger of the parallel development bodies with the PRI as in Karnataka. In this state, seventeen years after the merger of DRDAs with Zilla Parishads, the performance of in implementation as well as in ensuring financial propriety have been among the very best in the country. This is the best proof of the redundancy of the DRDA (and likewise other parallel bodies) in a system with strong PRIs.
- ❖ Retain the professional component of these parallel bodies as Cells or Units within the Zilla Panchayat carrying out their professional roles including management of funds and reaching out to all implementing agencies.
- ❖ Gram Panchyats must be adopted as the basic unit for monitoring of progress, submission of utilization certificates and release of funds.
- ❖ Perspective annual health plan must emerge from the village level which is to be collected after data collection on the health needs of the villages
- ❖ Train PRI officials on their roles with innovative strategies (through planned programs on Doordarshan with advance notice to the PRI functionaries which they must attend. The state should identify the health needs and programs should be planned accordingly. The knowledge of the functionaries should be periodically assessed to

provide continuous training on the gaps in knowledge. Local NGOs may also be involved. Training should be provided in local languages.

- ❖ Develop a separate cadre for PRI functionaries to enable them to have career opportunities

- ❖ Ensure participation of the community in the PRI institutions is vital to its success. While the system provides opportunities but still all this failed to ensure much direct participation. There could be many reasons for it like lack of awareness, a general apathy toward public affairs in the people, or a perceived powerlessness of these institutions and thus lack of incentives to participate etc. Active participation has been seen from some NGOs like Samarthan and PRIA and different areas like capacity building, social audits, planning etc. But it remained restricted to only some areas in the absence of consistent institutional support.

- ❖ As Gram Panchayats constituted for the units comprising multiple villages thus it further reduced the accessibility of the Sarpanch or Panchs to the people belong to villages other than villages where Sarpanch or Panch reside. Given the level of poverty and bad shape of connecting infrastructure, the accessibility of Janpad and Zilla Panchayats is reduced further. Also in the absence of any real power, there remains little interest to access these institutions for problem redressal. Absence of much active participation in Gram Sabhas also helped in reducing responsiveness as no other thing could enhance responsiveness than direct monitoring and questioning by people. With all these problems

- ❖ At the CHC level, two ANMs may be deputed concerned to help officials appointed to conduct social audit should visit the Gram Panchayat in advance and inspect the accounts, registers, and health status reports and works taken up under the health and sanitation programme. Details must be recorded in a prescribed format and be made available to the officials conducting social audit.

- ❖ Social Audit must be conducted on the specified day in two sessions: In the forenoon session, the officials must audit all registers and accounts and registers of the sub-

centre in the presence of the public, officials and elected members of the Gram Panchayats, ANMs of the sub-centre, and ASHAs' of the village covered. In the afternoon, the officials must inspect health and sanitation programmes, and also hold discussions with select beneficiaries on their perception about the performance of the sub-centres.

- ❖ The officials conducting social audit must also ascertain whether the accounts, registers and health status reports are maintained in the prescribed format as per rules.
- ❖ Officials conducting social audit must be given powers and responsibilities to undertake the following activities:
 - inspection of sub-centres and its activities,
 - conducting meeting of Village Health and Sanitation Committee (VHC),
 - holding discussions with the staff of sub-centre.
 - inspecting health and sanitation works in terms of quantity and quality of works undertaken,
 - admitting complaints about grievances,
 - inspection of minutes of VHSC meetings and action taken reports, and
 - assessing the accessibility of healthcare services in particular to Scheduled Casts and Scheduled Tribes.

A 2.4 Opportunities to Gram Sabha Members (Voters)

- during social audit, if any member of Gram Sabha wishes to know the details about accounts, registers and reports of sub-centres and activities of VHSC, the member should be given the opportunity to inspect records.
- all members of Gram Sabha should be allowed to be present while social audit is being pursued.
- Gram Panchayat Secretary / ANM of the sub centre must read out all records in the presence of everyone attending social audit.

A 2.5 Report of the social audit

- ❖ social audit officials must submit a social audit report to the CEO of Janpad Panchayat and president of Gram Panchayats covered within two days of completing the social audit. The report must clearly mention all positive aspects, irregularities and financial misuse. The report must also give constructive suggestions for corrective action.
- ❖ main findings of the report must be displayed at Gram Panchayat notice board in local language and vernacular so that general public can read and know the ground realities. Any member of the Gram Sabha can also avail full report by paying the prescribed fee.
- ❖ Gram Panchayat Secretaries must read the social audit report in the Gram Sabha meetings of the villages covered.
- ❖ CEO of Janpad Panchayat must instruct Gram Panchayats to follow-up the observations made in the report and take appropriate action within two days. The action taken report (ATR) must be prepared and submitted to the CEO within one month of the Gram Panchayat meetings.
- ❖ Social audit reports of all Gram Panchayats must be tabled in the Janpad Panchayat meeting. The CEO of Janpad panchayat must also discuss ATRs in a meeting of all the Gram Panchayat secretaries. CEO Janpad Panchayat should prepare a consolidated report of Janpad Panchayat as a whole and then submit it to CEO of Zila Panchayat who in turn must review follow-up actions taken and order disciplinary action in case of irregularities. CEO Zila Panchayat must also give powers to CEOs of Janpad Panchayats to take disciplinary action where necessary. CEO Zila Panchayat must also stipulate that the Chief Health and Medical Officer and district Project Manager of NRHM must conduct social audit in at least two sub centres in a year.
- ❖ The essence of social audit is to bring to the notice of general public, ground realities on the delivery of healthcare services and to build-up public pressure on the officials of NRHM to perform diligently and efficiently.

Chapter 9

Summary, Conclusions and Recommendations

The Central role of PRI in development has been time and again emphasized in the Plan documents both in The National Population Policy 2000 and the National Health Policy, 2001,

States were also asked to involve PRI in the implementation of Health and Family Welfare programs by progressive transfer of funds, functions and functionaries, by training, equipping and empowering them suitably to manage and supervise the functioning of health care infrastructure

and manpower and further to coordinate the activities of the works of different departments such as Health and Family Welfare, Social Welfare, and Education which are functioning at the Village and Block Levels.

SUMMARY AND CONCLUSIONS

At the State and the Level of Districts under Study

Madhya Pradesh Government has taken many significant steps to devolve functions, functionaries and finances related to various departments to the Panchayats. However these functions have not been transferred in their whole but State Government has kept significant part of them with itself and devolved only implementation, monitoring etc. to Panchayats. Functionaries transferred also remained employees of State Government and power of their transfer, posting, promotions etc. remain solely with the State Government departments. Even their assignment to Panchayats is decided by State Government. Panchayats also lack their own financial resources. The share of their financial resources to their total revenue base is very less. They are also lacking in expertise and capacity.

Political clout of the Panchayats depends on their relationship with upper level Governments. Madhya Government tilted it in its own favor by pursuing the policy of establishing a separate Zilla Sarkar at the district level with a Minister-in-charge appointed by State Government as its head and Zilla Panchayat President as its member. This step put Zilla Panchayats under the Zilla Sarkar when the opposite should have happened. The policy of having multiple parallel bodies at the local level effectively reduced the capacity and political clout of Panchayats. They are also lacking any effective influence over State Government. For their existence, they are completely dependent on the State Government.

Relationship between different levels of Panchayats also influences their power base. Majority of funds and functions are directly assigned to the Gram Panchayats and Gram Sabhas. Janpad and Zilla Panchayats lack any effective power over them. Funds sanctioned for health and family have been insufficient. No hierarchy has been established between different levels of Panchayats and they work as independent layers. This reduces any control of Janpad or Zilla Panchayats on Gram Panchayats. As Janpad and Zilla Panchayats also lack resources so they cannot plan for development schemes across the villages. Within the present setup, Zilla Panchayats and Janpad Panchayats lack any effective executive power. In the Zilla Sarkar (District Government) model of administration, the scope of District Planning Committees (DPCs) was enhanced from their primary task of planning to execute the tasks assigned to them by State Government. PRIs were primarily entrusted with the task of monitoring, supervision and implementation through line departments. DRDA was merged with Zilla Panchayat but it maintained its separate existence. Zilla Panchayat president was entrusted with the responsibility of heading the DRDA. Both Zilla Panchayat president and DRDA director were also members of the DPC.

The powers and responsibilities given to the Zilla Sarkar made them very powerful bodies and thus reduced the scope of functioning of Zilla Panchayats. DRDAs were also not abolished and Central Government executed programs, including that of health and welfare through DRDA effectively sidelining PRIs. This new setup created multiple independent parallel bodies entrusted with different functions with very little interlink between them.

The PRI's also lacked capacity and expertise to carry out the tasks of supervision, monitoring and implementation of the schemes regarding health and family welfare. These tasks therefore remained as they were and with the officials.

The study found that in actual implementation, state government, in actual practice was not much desirous to transfer effective powers, resources and authority to the local bodies. This lack of political will coupled with bureaucratic covert resistance to shed 'power' has led to PRI's limited role in health matters.

The MP government also provisioned for PRI's, provisions to recruit village level class III and IV functionaries like panchayat secretaries, school teachers, Aaganwadi workers by the Panchayats themselves at the retirement of the old staff. The State stopped the policy of recruiting permanent teachers and they were replaced with Para-teachers called Shiksha Karmis. All new recruitment for Shiksha Karmis was to be done by Janpad or Zilla

Panchayats on the recommendations of Gram Panchayat and control. In the districts under study, however, this is still being done by the government officials.

There was also a lot of ambiguity in the powers of the health department and the Panchyats and there is no separation of powers between the role and Panchyats and the health departments.

Devolution and transfer of funds to PRI is a critical must for PRI empowerment on matter related to health and family welfare. This has only been done on paper and not in actual practice can be expected to play a meaningful.

PRESENT STATUS DEVELOPMENT OF INFRASTRUCTURE FACILITIES FOR HEALTH CARE DELIVERY AND THEIR DELIVERY

Physical Infrastructure

- ❖ In most of the districts under study there was lack of equipment, buildings needed repairs, complementary facilities like clean water and 24 hour electricity back-ups were found wanting and so on.
- ❖ Provision of infrastructure facilities in a number of CHCs, PHCs & Sub Centres exist but their conditions are not good at the district level.
- ❖ Only two CHCs had fully functional X-ray machine.
- ❖ Sub-Centers in the districts under study were manned by one Auxiliary Nurse Midwife and one male Multi-purpose Worker. While they are to be provided with adequate medicines for minor ailments, those required for immunization, diarrhea control, and control of communicable diseases were in short supply. Subentries were providing services related to PNC and ANC.
- ❖ Maintenance of infrastructural facilities and hygiene and sanitation were found be unsatisfactory.
- ❖ Operation theatre was available in only two PHCs
- ❖ MOs were not visiting once a month as stipulated
- ❖ Primary Health Centers (PHCs) were hardly concentrating on the preventive and primitive aspects of health. The infrastructure for in patients was quite dilapidated. Since these were used largely for delivery cases, women preferred to stay for the minimum time.

- ❖ CHC were short of staff and instead of four medical specialists including Surgeon, Physician, Gynecologist, and Pediatrician along with the Para medical staff, only some general physicians were available. Emergency Obstetric care was available in tow CHCs. Six CHS, this service was missing as there were no lady doctors
- ❖ Emergency services for sick children were available in all the eight CHCs although only one of them had a Pediatrician doctor
- ❖ There was acute manpower shortage at the PHC and CHC levels. Many villages have Anganwadi workers but these are not trained health providers.
- ❖ There medical staff is inadequate as the actual strength has been much less than the sanctioned one.

Availability of medicines is an issue. Some of the beneficiaries complained of spurious medicines being given to them. Many also reported large scale corruption in the purchase of medicines.

- ❖ In some PHCs, Pharmacists are in-charge of the PHC (P.33).
- ❖ Lab test facilities were available only at the district level.
- ❖ Lady Doctors at the PHC level were insufficient compared to the need.

Hospitals, at the district level were primarily being used for delivery care and child health care. The insufficiency of these services at the PHC and CHC level has put additional pressures for these services at the district level. As a result, treatment and care of patients with diseases like Malaria, respiratory infection other than TB and other diseases has been neglected.

ROLE OF PRI AT THE THREE LEVELS AND THE IMPEDIMENTS

Gram Panchyats (GPs)

- ❖ Their representatives in GP did not raise beneficiaries' health care concerns.
- ❖ There was indifference among the people in taking up health care issues in the Gram Sabha's
- ❖ Gram Panchyats do not have any budgetary provisions for health care and reproductive health care.
- ❖ Discussions at the GP level were guided by the availability of funds. These were available for provision of water, repairing village roads, poverty alleviation and so on and not on health needs of the community.
- ❖ Health and family welfare issues were totally neglected in the meetings. More time was spent on non-health issues like repair and maintenance of buildings and furniture and alterations and additional construction in buildings.
- ❖ GP officials were of the opinion that health care is the responsibility of the health department

Sub Centers (SCs)

- ❖ Proportion of population using SCs is very low. The maximum usage was in Bhopal and the minimum in Morena.
- ❖ Service delivery at the SCs level mostly focused on maternity and child care.
- ❖ Impediment: Sub Centers were totally neglected in the provision of health care issues both by the Government officials and the PRI representatives

Primary Health Centers (PHCs)

Specific lab-test facilities with a trained technician were available in all the districts.

Bed occupancy ratio was good and health care facilities were available round the clock

The physical infrastructure, in the context of separate labour rooms, availability of medicines, availability of IPS services with beds (6each), new born, ANC, PNC facilities were available.

Community Health Centers (CHCs)

- ❖ Most of the services provided related to AANC, PNC and child care including Immunization.

Rogi Kalyan Samiti's (RKS)

- ❖ All the non-medical personnel of RKS have been attending its meetings as a mere formality with no interest in the follow up of the decisions taken at the meetings.
- ❖ The bureaucrats and the elected members of the Jan Pad have a very casual attitude towards health matters

Zila Panchyats (ZPs)

- ❖ District Health societies chaired by the respective district collectors along with the CEOs of the ZPs have been functioning satisfactorily. The meetings reviewed the health status based on the reports of RKS at the CHC and PHC level and remedial measures were suggested.
- ❖ There has been adequate availability of infrastructural facilities like blood storage facility, proper sanitation, doctor's room, pharmacy, etc.
- ❖ Hospitals, however, were primarily being used for delivery care and child health care. The insufficiency of these services at the PHC and CHC level puts additional pressures for these services at the district level. As a result, treatment and care of patients with diseases like Malaria, respiratory infection other than TB and other disease has been neglected.

Impediments and Constraints

Gram Panchayats (GPs)

- ❖ Health care issues are hardly discussed at the GP level
- ❖ GP meetings are guided by the availability of funds for different heads . There are little funds for health care.
- ❖ GP Secretaries mostly were educated up to the metric level and not able to comprehend the health issues. Also had a low understanding of the issues, roles and responsibilities
- ❖ At the GP level the beneficiaries felt rampant corruption of the untied funds due to lack of supervision and accountability

Primary Health Centres (PHCs)

- ❖ AYUSH services were not available in 6 out of 8 PHCs
- ❖ PHCs have inadequate staff including those without a single doctor. There was negligible emphasis on preventive health care.
- ❖ Less than one-third of the beneficiaries were using the services of PHCs the lowest level was in Bhopal district and the highest in Sidhi district.
- ❖ The services provided by the PHCs were mostly related to ANC, PNC, Child health care and family welfare
- ❖ Sanctioned positions of medical personnel had not been filled up in many PHCs under study.
- ❖ In one PHC, Pharmacists are in-charge of the PHC (P.33)
- ❖ There was an undue deployment of non-medical manpower in fairly large proportions at the PHC level.
- ❖ The health department does not function in coordination with the panchayats (p.51-52)
- ❖ The staff of other departments does not consider themselves accountable to the Panchayats.
- ❖ There was inadequacy of funds has been an important factor in the poor quality of services

Community Health Centres (CHCs)

- ❖ No Special services were available at the CHC level. At best they were referring them to the District level.
- ❖ Facilities for Caesarian operations are practically absent as also the lack of anesthetic services
- ❖ Labour rooms in six CHCs were not even fit to be used as store rooms.
- ❖ The Medical personnel in position are less than the numbers sanctioned.
- ❖ Obstetric facilities were available only in two CHCs as there were no lady doctors in these districts

BENEFICIARIES SATISFACTION/DISSATISFACTION

- ❖ Availability of Doctors is a major area of dissatisfaction in districts other than Bhopal and Tikamgarh.
- ❖ In Sidhi and Tikamgarh doctors care was a major concern.
- ❖ A low percentage of respondents were using the services of SCs, PHCs and CHCs.
- ❖ The satisfaction levels with the Sub Centers were the highest in Bhopal and Lowest in Morena. Other sub centers also had low levels of satisfaction with the services of the SCs.
- ❖ At the PHC level too, availability of doctors and doctors care was an area leaving to dissatisfaction amongst the respondents. In some PHCs like Sidhi and Tikamgarh, the level of dissatisfaction was highest.
- ❖ At the CHC level, While their dissatisfaction with the medical and paramedical staff and health was low across the districts (except Bhopal), it was the highest in Tikamgarh district particularly with respect to doctors and paramedic staff's availability and care by the doctors.
- ❖ At the CHC level majority of the respondents were dissatisfied with a wide range of services in Balaghat, Bhopal, Dhar, Morena and Sidhi CHCs.
- ❖ Doctors availability, care for the patients was a major area in most of the CHCs.
- ❖ There was a high level of dissatisfaction with the quality of health care services and reproductive health care.

SUCCESS STORIES

The success stories of gram of SC show The GP President showed vision and concern for health care of the community and energized its members who also played an active role in seeking donations from the industries. This government also responded positively and the SC was upgraded to the PHC level. The GP also made sure to provide health care based on the needs of the population. A case in point is the regular visits by a TB specialist in one village where 90% of the population was suffering from this disease.

Resource mobilization by the two GPs and public private partnership has been the major factors contributing to the success of provision of health care facilities.

MODEL STRUCTURE OF RURAL HEALTH CARE WITHIN THE FRAMEWORK OF PANCHYATI RAJ SYSTEM

- ❖ In the proposed alternative model SCs and PHCs will focus establishing firm linkages with rural population at the grass root level to build up awareness about public health facilities and to improve their access to public health institutions. This is in addition to their basic function of providing primary health care and facilitating out reach to higher level public health institutions through optimal use of referral transport system.
- ❖ CHCs will provide hospitalization services to all those who require OPD and IPD facilities. CHC will, in coordination with DHM, attempt to fill vacancies of all medical officers, staff nurses and other paramedical staff through contractual appointment of local accredited health professionals with the skills that the grass root level (CHC, PHC & SC) system does not have. This is to ensure that each PHC has at least one medical officer and a staff nurse; and the CHC should have teams of medical officers to facilitate regular and periodic visits at least thrice a week to each sub centre. CHC should also outsource maintenance of equipment and vehicles provided; and cleanliness, catering and waste management services in order to reduce workload on regular health officials and to bring about improvements in the quality of health services at CHC, PHC and SC levels. RKs and CHC and PHC levels should be restructured to comprise largely of users to facilitate community ownership of CHCs, PHCs and SCs.
- ❖ District Health Mission (DHMs) have a pivotal role in decentralized planning, implementation and monitoring and evaluating progress of health development. DHM should out source to external auditors internal financial audit of DHM, CHC, PHC and SC. DHM should also assist the divisional office in regular and periodic performance audit and social audit of the quality and extent of coverage of public health facilities under NRHM.
- ❖ Divisional level can play a crucial role by undertaking the following activities
 - * Accounts and financial management
 - * Procurement, storage and logistics of medicines and equipment
 - * Administration and planning
 - * Infrastructure and equipment development and reviewing their maintenance

- * Improving association of NGOs and CBOs and coordinating their active involvement in planning, implementation, and monitoring and evaluation of health development for poor in particular
 - * Reviewing the functioning of District Hospitals, CHCs, PHCs and SCs through regular and periodic performance and social audits, and initiating appropriate and timely corrective action at the concerned levels.
 - * Establishing resource group of professionals in all the relevant specialization and ensuring their period visits district hospitals and CHCs for treatment of patients at the respective locations.
- ❖ In the revised model proposed CHCs, PHCs and SCs will focus attention on providing health care, while DHMs and Divisional Offices will be vested with administration, financial management, performance management, improving association of NGOs and CBOs and extending services of specialists to District Hospitals, and CHCs and continuous improvement in the quality of health services.
 - ❖ All development institutions have to be harmonized with the PRI set up or else they become ultra vire the Constitution. There are different possible courses of action to deal with parallel bodies. They include:
 - ❖ Taking recourse to total merger of the parallel development bodies with the PRI as in Karnataka. In this state, seventeen years after the merger of DRDAs with Zilla Parishads, the performance of in implementation as well as in ensuring financial propriety have been among the very best in the country. This is the best proof of the redundancy of the DRDA (and likewise other parallel bodies) in a system with strong PRIs.
 - ❖ Retain the professional component of these parallel bodies as Cells or Units within the Zilla Panchayat carrying out their professional roles including management of funds and reaching out to all implementing agencies.
 - ❖ Gram Panchyats must be adopted as the basic unit for monitoring of progress, submission of utilization certificates and release of funds.
 - ❖ Perspective annual health plan must emerge from the village level which is to be collected after data collection on the health needs of the villages
 - ❖ Train PRI officials on their roles with innovative strategies (through planned programs on Doordarshan with advance notice to the PRI functionaries which they must attend. The state should identify the health needs and programs should be planned accordingly. The knowledge of the functionaries should be periodically assessed to

provide continuous training on the gaps in knowledge. Local NGOs may also be involved. Training should be provided in local languages.

- ❖ Developing a separate cadre for PRI functionaries to enable them to have career opportunities.
- ❖ Ensuring participation of the community in the PRI institutions is vital to its success. While the system provides opportunities but still all this failed to ensure much direct participation. There could be many reasons for it like lack of awareness, a general apathy toward public affairs in the people, or a perceived powerlessness of these institutions and thus lack of incentives to participate etc. Active participation has been seen from some NGOs like Samarthan and PRIA and different areas like capacity building, social audits, planning etc. But it remained restricted to only some areas in the absence of consistent institutional support.

RECOMMENDATIONS

- ❖ Shift from the Zilla Sarkar Model to the PRI Model: While Zila Prishads representatives help in preparation of the agenda and some decisions are taken but these have a strong stamp of the District Collector and other district level officials. The hospitals at the district level do provide services which are based on the demand rather than a planned strategy to look after the health of the community. But this functioning has not much to do with PRI or their representatives. The Zila Praishad members have their own priorities and often the agenda does not reflect the needs of the community. GPs have failed to deliver. All development institutions have to be harmonized with the PRI set up. This can be done by: taking recourse to total merger of the parallel development bodies with the PRI as in Karnataka. In this state, seventeen years after the merger of DRDAs with Zilla Parishads, the performance of in implementation as well as in ensuring financial propriety have been among the very best in the country. This is the best proof of the redundancy of the DRDA (and likewise other parallel bodies) in a system with strong PRIs.
- ❖ Retain the professional component of these parallel bodies as Cells or Units within the Zilla Panchayat carrying out their professional roles including management of funds and reaching out to all implementing agencies.
- ❖ Perspective annual health plan must emerge from the village level which is to be collected after data collection on the health needs of the villages
- ❖ PRI officials should be continuously trained on their roles with innovative strategies. Doordarshan is viewed everywhere in the villages. The GP members' can be asked to pinpoint their understanding of the health care needs and planned programs in which attendance of the GP members and the village community can be ensured. Health care knowledge gained through such programmes of the functionaries should be periodically assessed to provide continuous training on the gaps. Local NGOs may also be involved. Training should always take place in in local languages.
- ❖ Develop a separate cadre for PRI functionaries to enable them to have career opportunities
- ❖ Ensure participation of the community and the NGOs in the PRI institutions. While the system provides opportunities but still all this failed to ensure much direct participation. There could be many reasons for it like lack of awareness, a general

apathy toward public affairs in the people, or a perceived powerlessness of these institutions and thus lack of incentives to participate etc.

- ❖ PRI as an institution will succeed with the commitment of the political class to devolution of funds in general and for health and family welfare to this institution. The study highlights that agenda and discussions are led by the availability of funds under different heads where actual health hardly figures and issues like repair of roads provision of water and the programmes of the government at the rural level are discussed.
- ❖ Enhance responsiveness, monitoring and questioning by people. As Gram Panchayats constituted for the units comprising multiple villages thus it further reduced the accessibility of the Sarpanch or Panchs to the people belong to villages other than villages where Sarpanch or Panch reside. Given the level of poverty and bad shape of connecting infrastructure, the accessibility of Janpad and Zilla Panchayats is reduced further. Also in the absence of any real power, there remains little interest to access these institutions for problem redressal. Absence of much active participation in Gram Sabhas also helped in reducing responsiveness as no other thing could enhance responsiveness than direct monitoring and questioning by people.
- ❖ Ensuring sufficient availability of funds for health and family welfare. The study highlights that agenda and discussions are led by the availability of funds under different heads where actual health hardly figures and issues like repair of roads provision of water and the programmes of the government at the rural level are discussed. Infact the GP representatives do not act like representatives of the community and go by the flow of the agenda which is devoid of health related issues. Their own understanding of the health related issues is low as the community also does not raise such issues with them. The Rogi Kalyan Samitis have been created as a medium through which PRIs can make effective intervention in health but these have remained ineffective. The Jan Pad Panchyats do not have health care as a direct subject under their sphere.
- ❖ Coordination between PRS and Health Care System: The study revealed that PRIs and primary health institutions have cordial relations only at the district level. At SC and PHC levels, although there are committees to promote linkage between the two,

in many cases PRIs are not aware of their roles and responsibilities vis-à-vis health care, and not serious about their association with the public institutions delivering health care.

Some other recommendations have been made in the chapter on alternative Model structure of PRIs.

Mobilizing resources locally by any PRI is an approved strategy for development under the PRS. Hence, this experiment is replicable. Cooperation and active GP's and public support have been the key elements of the strategy for health care development. This strategy is part of the functional responsibilities of PRIs. Hence, it is replicable.

ANNEXURE-1

Management of Health Services at PHC Level

Rural health services could gain public confidence only when provided optimally with specialist support facilities and in a transparent and accountable manner, which calls for adequacy of resources, power to use the same in most patient-welfare-centric ways and with involvement of the citizens.

Rogi Kalyan Samiti (RKS) is the response of the state of Madhya Pradesh to the challenge of inadequate resources of hospitals and citizens' engagement in the issue of healthcare delivery. It is the state's attempt to make "Health everyone's business by de-mystifying the healthcare delivery at district and sub-district levels", especially with reference to facility based healthcare delivery and encouraging citizens participation in the facility management bodies.

RKS is the hospital based management committee, registered as society under the Madhya Pradesh Societies Registration Act 1973. These are to be constituted in all the public hospitals, from Primary Health Centre through Community Health Centre and civil hospital till District hospital tier as facility based management bodies with the core intent of patient welfare, augmenting hospital facilities and services with the participation of local people.

RKS (Patient Welfare Committee) is a management structure. This committee acts as a group of trustees for the hospital to manage the affairs of the hospital. Other than the facility staff, it consists of members from local Panchayati Raj Institutions (PRIs), legislative body, civil society and officials from Government sector who are responsible for proper functioning and management of the hospital/Community Health Centre/First Referral Units.

RKS is free to prescribe, generate and use the funds with it as per its best judgment for smooth functioning and maintaining the quality of services for patient welfare. RKS has the following Objectives:

Objectives of RKS

1. Improve the management of the hospitals with citizens' participation
2. To ensure user-friendly behaviour amongst service providers for efficient healthcare delivery
3. To arrive at the "Minimum Service Guarantee" at the facility through consensus of RKS members and publicly display the same through "Citizens Charter" and complied with public domain.
4. Display a Citizens' Charter in the Health facility and ensure its compliance through operationalization of a Grievance Redressal Mechanism
5. To work towards up-gradation of health institution, modernization of health facilities and purchase of essential equipment for the institution. To effect a continual upgradation of the facility in response to the patient needs and load with reference to the profile of patients and the treatment requirement i.e. Maternal Child Health Services, Family Planning Services, Communicable and non communicable diseases.
6. Provide assured ambulance services for emergencies and during accidents to the patients within the radial jurisdiction (catchments area) of the facility and the out/in-patients who need referral transport.
7. Arrange for good quality diet, and drugs and stay arrangements for the patients and their relatives/attendants.
8. To ensure equity through provision of free treatment to patients below poverty line, socially and economically backward groups and mechanisms to cover their access costs (transport, diet, attendants' stay etc.).
9. To undertake special measures to reach the un-reached / disadvantaged groups.
10. Provide supervision to maintenance and expansion of hospital building.
11. Ensure an efficient and rational use and management of hospital land and building.
12. Organize training and workshops for staff members in their public dealing and counseling methods.
13. To provide supervision to ensure adequate and safe disposal of hospitals wastes.
14. To ensure proper maintenance of Hospital, Wards, Beds, Equipments including provisioning of safe drinking water and toilets and cleanliness of premises.
15. To ensure easy access to facility based social protection programmes i.e. Janani Suraksha Yojana, Deen Dayal Antyodaya Upchaar Yojana, Rashtriya Swastha Bima Yojana and National Health Programme etc.

16. To participate in the district health planning process to ensure the specific disease profile and patient requirements are included in the budget projections and annual plans.

Specifically RKS is required to undertake the following activities:

Activities of RKS

- Prioritize core patient care-expenses/investments (life-saving drugs, essential medicines, surgical equipments and consumables, disposable assets, dietary services, cleanliness etc.
- Identify the problems faced by the patients with frequent interactions and formal feedback mechanisms capturing the following:
 - Accessibility of the clinical care staff
 - Availability of medicines
 - Timely service
 - Attitude of staff
 - Ease of obtaining subsidies
 - Ease of registration and paperwork/administration
 - Overall patient satisfaction
- Procurement & management of blood for appropriate treatment and care purposes.
- Improve boarding/lodging arrangements for the patients, good quality/therapeutic diet and drugs and lodging facilities for the patients' attendants.
- Make the hospital a safe, auto-guided space (with signage, stewards-in-uniform and counseling staff).
- Generate resources through partnerships with non-state actors / private entrepreneurs, levy of user charges in consultation with civil society representatives for on-going facility upkeep, maintenance.
- Ambulance services for emergency (both for out/in-patients and patients in the catchments area of the institution).
- Provide free treatment to Below Poverty Line (BPL) patients and set up mechanisms to offset their treatment (indoor, outdoor) cost.

- Making arrangements for proper maintenance of Hospital Buildings, Wards, Beds, Equipments, and cleanliness of premises.
- Ensure voluntary citizens' participation in the maintenance and upkeep of the hospital
- Organize training and workshops for staff members with reference to public/ patient dealing
- Up gradation of facilities, hospital premises and equipment.
- Commercial use of extra unused land for additional resource generation through prescribed procedures and transparent manner where patient welfare and hospital space efficiency is not compromised.
- Ensure single window facilitation for accessing of social protection schemes (including National Health Programmes) run by state and Govt. of India which are availed at the facility i.e. Janani Suraksh Yojana and Deen Dayal Antyodaya Upchaar Yojana, Rashtriya Swastha Bima Yojana et al.

Rogi Kalyan Samiti at each level has two bodies for its effective functioning:

1. Executive body: The Executive Committee will act as a "Board of Trustee" for the hospital and a watchdog to over-see the day to day functioning of the same.
2. General Body

Composition of the Executive Body

* (BMO in case of CHC and in PHC/In-Charge Medical Officer)5 - Chairperson

5 In case the hospital doesn't have a Block Medical Officer, the In-Charge Medical Officer who is the BMO designate, will chair the proceedings.

| | | |
|---|---|--------|
| * | Tehsildar/Naib Tehsildar | Member |
| * | Sub Engineer, Public work Dept | Member |
| * | Sub Engineer, Madhya Pradesh State Electricity Board | Member |
| * | Women and Child Development Supervisor (Head-Quarter position) | Member |
| * | One Donor (with donation upto Rs.25,000/-) (in case of multiple donors, he/she who has | Member |

donated maximum will be nominated as member)

- * Three people's representatives. (preferably Member
Two of which should be from the Swasthya
Gram Samiti ratified by SDM)
- * In-Charge Medical Officer Hospital Member Secretary

General Body:

- * Janpad Panchayat President (in his absence, Chairman
Chairman of the Health Committee)
- * BMO/In-Charge Medical Officer Member
(chair of the Executive Committee)
- * President Nagar/Gram Panchayat/ Member
Municipality
- * Tehsildary/Naib Tehsildar Member
- * President of Health Committee Member
- * Nagar/Gram Panchayat female Member Member
- * In-Charge/Sub Engineer, Public Works Member
Dept
- * In-Charge Madhya Pradesh Member
State Electricity Board
- * Two Donors (donated Rs.25000/) (In case Member
of multiple donors, he/she has donated
maximum will be nominated as member)
- * In-Charge Medical Officer, Hospital Member Secretary

Powers and Responsibilities of General Body of Rogi Kalyan Samiti⁶

1. The General Body shall meet at least once in a year. However the Executive Committee or 1/3rd members on request can call meetings of Rogi Kalyan Samiti.
2. The newly constituted Rogi Kalyan Samiti shall hold its meeting within 3 months and shall elect its office bearers.
3. The agenda of meeting of the general body needs to be circulated, preferably a fortnight before the meeting, at least a week before the scheduled meeting (in case a fortnight is not possible) and the call for the general body meeting and the agenda will be served to each member.
4. Membership, induction, removal et al will be ratified by the general body
5. The quorum of the General Body shall be 1/3rd of the members.
6. The General Body shall take the policy decisions and it will be implemented by the Executive Committee of Rogi Kalyan Samiti.
7. General Body will approve financial proposals that are beyond the powers of the Executive Committee.
8. The General Body shall review the financial account at least once in a financial year, review income and expenditure statements and shall approve the budget for the next year.
9. General Body shall have powers to constitute sub committees for specific purposes like new constructions, commercial use of land et al.

Powers and Responsibilities of Executive Committee

1. The Executive Committee (EC henceforth) will meet at least once in two months. The quorum will be of 50% members. The presence of the Chairpersons will be essential.
2. Executive Committee will implement the decisions taken by the General Body and will function within its powers vested by the General Body.
3. Executive Committee can delegate its financial powers to the Member Secretary.
4. Executive Committee shall have the authority of raising the funds for the activities approved by the General Body including raising of bank loans under authorization from the General Body.
5. The Executive Committee can appoint Medical/Para-Medical staff, cleanliness staff and security guards and part time employees on contract for maintenance and upkeep of the facility. These services can also be outsourced by RKS.
6. EC shall review the Out Patients' Department and In Patients' Department services performance of the hospital every quarter.
7. EC shall review the quality and range of services provided to patients (from socially and economically backward groups) and other un-reached and disadvantaged communities.
8. EC shall review Outreach work of the hospital
9. EC shall review the status of utilization of funds, equipment, drugs and any other assistance received under different programs of the Government (State and Centre).
10. EC shall review compliance to Citizens Charter displayed in Hospital and the effectiveness of the Grievance Redressal Mechanism.
11. EC will levy user charges from the patients (of non-BPL, non-poor category) and facilities to be given to patients and their relatives.
12. EC can purchase equipment, drugs, furniture, Pathological reagent, X-ray films in consultation with the Senior Medical Officer for quality purchase.
13. EC will ensure rational allocation of resources to patient welfare i.e. giving priority to essential and/or life-saving drugs and provisioning for equipments, operations and maintenance et al.
14. Hospitals' maintenance i.e. minor repair, construction, amenities for patients like waiting area, drinking water provisioning, dietary services for patients (with and sans payment) et al will be funded by EC.

15. EC will ensure financing and provisioning of sonography CT Scan, MRI, physiotherapy, burn unit, ICCU, dialysis and staffing of the same. The out-sourcing and contracting modus7 can be explored for the purpose as long as the transparency of tendering and contracting is maintained.
16. Scientific disposal of bio-medical waste.
17. EC will make plans and projects of RKS and disseminate them widely for encouraging wider participation.
18. EC will work towards securing tax exemption and requisite clearances from the IT Dept other concerned state and central departments.
19. EC will decide the remuneration of the maintenance and other support staff from the RKS funds.
20. EC will get the financial accounts of RKS audited once a year and the RKS account will be opened in a nationalized bank.
21. EC will constitute a "purchase committee" from amongst its members and/ or outside associates if needed for transparent and effective transactions.
22. On inspection of health institution recommendations and suggestions of members of RKS will be given importance and action will be taken accordingly (especially in terms of attendance of doctors and para-medical staff)

ANNEXURE 2

Janpad Panchayats and Health Care

Powers of Janpad Panchayat

Subject to the provisions of this Act and the rules made there under, and subject to general or special orders, as may be issued by the State Government, from time to time, it shall be the duty of a Janpad Panchayat, so far as the Janpad Panchayat funds allow, to make reasonable provision in the Block for the following matters, -

- a) Integrated Rural Development, Agriculture, Social Forestry, Animal Husbandry and Fisheries, Health and Sanitation, Adult Education, Communication and Public Works, Co-operation, Cottage Industries Welfare of Women, youth and children, welfare of disabled, and the destitute and welfare of backward classes, family planning and sports and rural employment programmes;
- b) provision of emergency relief in cases of distress caused by fires, floods, drought, earthquake, scarcity, locust swarms, epidemics and other natural calamities;
- c) arrangement in connection with local pilgrimage and festivals;
- d) management of public ferries;
- e) management of public markets, public meals and exhibitions; and
- f) any other function with the approval of the State Government or Zilla Panchayat.

Functions of Janpad Panchayat

Subject to the provisions of this Act and rules made there under and subject to Policy, directions, instructions, general or special orders as may be issued by the State Government from time to time, it shall be the duty of the Janpad Panchayat to:

- i) prepare the annual plan in respect of the schemes of economic development* and social justice entrusted to it by the Act and those assigned to it by the State Government or the Zila Panchayat and submission thereof to Zila Panchayat within the prescribed time for integration with the District Panchayat Plan;*
- ii) consider and consolidate the annual plan in respect of the scheme of economic development and social justice of all Gram Panchayats and the Janpad Panchayats and submission of the consolidated plan to Zila Panchayat;
- iii) prepare plan of works and development schemes to be undertaken from Janpad Panchayat Fund;
- iv) undertake regional planning and infrastructural development within the Janpad Panchayat;
- v) sanction, supervise, monitor and manage the works of development schemes from Janpad Panchayat Funds and for this purpose incur expenditure there from;
- vi) ensure the execution of schemes, works, projects entrusted to it by any law and those assigned to it by the Central or State Government or Zila Panchayat;

* Economic development here includes health care and sanitation.

- vii) implement, execute, supervise, monitor and manage works, schemes programmes and projects through Gram Panchayat or through executing agencies, transferred by the State Government to Panchayats;
- viii) recommend for the consideration of Zila Panchayat any works or development schemes which could be taken up by the Zila Panchayat in the block, and indicate the extent to which local resources are likely to be available in such works or schemes;
- ix) co-ordinate and guide the Gram Panchayats within the block;
- x) secure the execution of plans, projects, schemes or other works common to two or more Gram Panchayats in the block;
- xi) reallocate to Gram Panchayats funds made available by Central or State Governments or the Zila Panchayat pertaining to the transferred schemes, works and projects as per the norms fixed by the Central or State Government or the Zila Panchayat, as the case may be;
- xii) take all necessary measures to mobilize resources by exercising the powers entrusted to it by any law or the Central or the State Government;
- xiii) exercise and perform such other powers and functions as the State Government may entrust to it.

Budget of Janpad Panchayats vis-à-vis Public Health and Safety

Rs.20 lakh/CHC to two CHCs in every district for bringing them on par with IPHS.

Maintenance grant of Rs.1 lakh per CHC, after constitution of Rogi Kalyan Samiti at that level.

Untied fund of Rs.10,000 per Sub-centre.

Supply of additional drugs (allopathic and AYUSH) at Sub-centre, PHC and CHC level.

Mobile Medical Unit for district. 50% districts in EAG states to get Rs.10 lakh/district for district planning funds for training of ASHAs.

- Registration (within 12 weeks)
- Physical examination + weight + BP + abdominal examination
- Identification and referral for danger signs
- Ensuring consumption of at least 100 IFA tablets (for all pregnant women)/200 (for anaemic women). Severe anaemia needs referral.

- Essential lab investigations (HB%, urine for albumin/sugar, pregnancy test)
- TT immunization (two doses at interval of one month)
- Counselling on nutrition, birth preparedness, safe abortion, Family Planning and institutional delivery
- Assured referral linkages for complicated pregnancies and deliveries
- Counselling for Feeding, Nutrition, Family Planning, Hygiene, Immunization and postnatal check-up
- Home visits on 3rd, 7th and 42nd day, for both mother and baby. Additional visits are needed for the newborn on day 14, 21 and 28. Further visits may be necessary for LBW and sick newborns.
- Timely identification of danger signs and complications, and referral of mother and baby
- Warmth
- Hygiene and cord care
- Exclusive breastfeeding for 6 months
- Identification, management and referral of sick neonates, low birth weight (LBW) and pre-term newborns
- Referral linkages for management of complications
- Care of LBW newborns <2500 gm
- Zero day immunization OPV, BCG, Hepatitis B

Dhanwantari Block Development Scheme (DBDS)

Background

This scheme has been started with the vision of attaining the best management practices and effective implementation of existing different activities to ensure better health care to the women, children and marginalized people of the society.

- To ensure best quality care health services to the women, children and under privileged section.
- To put sincere efforts to improve the healthy status for the children, women and needy
- Make available all the medical requirement/services of that they are in the reach of all the stakeholders.

Salient Features

As an innovative initiation, DBDS has been started in 50 blocks of the state on a pilot basis. A need was felt to approach holistically and integrate major activities in the form of package for under-served and under-privileged groups of society.

The following 13 major health services are clubbed together:

- Full immunization
- Full Ante Natal Care (ANC)
- All deliveries in institutions
- Full care of all malnourished children under Bal Sahkti Yojana
- Deendayal Cards for eligible families
- Extend full benefits of Janani Suraksha Yojana (JSY) and Prasav Hetu Parivahan evam Upchar Yojna to all target facilities
- Ensuring of availability permanent and temporary methods of family planning to all qualified couples
- Designating of depot holders for essential drugs and family planning devices

- Explain the usage of ORS to all families of the block
- Disseminate knowledge to identify the symptoms of pneumonia
- Health checkup for all school children
- Ensuring minimum age of 18 years for marriage of girl children
- Ensuring availability of all the public health facilities to the poor patients.

4.7 Management of Health Services at CHC Level

There is a Rogi Kalyan Samiti (RKS) at the Janpad Panchayat level. For the day-to-day management of the CHC and RKS the Executive body will consist of;

Executive Body : For the day-to-day functioning of the hospital and RKS

| | | |
|---|---|---------------------|
| * | Chief Medical Health Officer | Chairman |
| * | Sub Divisional Officer/Magistrate (in absence of CMHO, SDM will chair the meeting) | Member |
| * | Sub Divisional Officer, PWD | Member |
| * | Two Senior Medical Officer out of which one could be a Lady Doctor | Member |
| * | One Donor (with minimum donation of Rs.50,000/) (in case of multiple donors one who has donated maximum will be nominated as member) | Member |
| * | Two social workers with proven track record in health activism (proposed by the Executive Committee and ratified by the collector) | Member |
| * | In-charge Civil Hospital | Member |
| * | Block Medical Officer (in case of Community Health Centre-CHC) | Member Secretary |

In case of absence of CMHO, the SDM will chair the meeting in case of CHC and the In-charge Civil Hospital in case of Civil Hospital RKS

General Body:

The CHCs, civil hospitals and other hospitals at the Tehsil & Block Level come under this category. The composition is as follows:

| | | |
|---|---|----------|
| * | Member, Legislative Assembly of the area | Chairman |
| * | CMHO | Member |
| * | Sub-Divisional Officer/Magistrate | Member |
| * | President Janpad Panchayat/Nagar Palika | Member |
| * | CEO Janpad Panchayat | Member |
| * | DE/Assistant Engineer, Madhya Pradesh State Electricity Board | Member |

| | | |
|---|---|---------------------|
| * | SDO, Public Works Dept | Member |
| * | SDO, Police | Member |
| * | One Donor (who has donated Rs.50,000/) (in case of multiple donors who has donated maximum will be nominated as member) | |
| * | Press Representative | Member |
| * | Senior Medical Officer nominated by CMHO | Member |
| * | Child Development Programme Officer | Member |
| * | In-charge Civil Hospital, BMO In-charge CHC | Member Secretary |

Powers and functions of General Body and Executive Committee of RKS at CHC level are the same as outlined in sector 3.4 of Chapter 3.

ANNEXURE 3

Health Care by the District Health Mission

As part of the NRHM strategy, it is required to develop a health management team with a strong District Health Mission with the following roles and responsibilities:

- Planning, implementing, monitoring and evaluating progress of Mission
- Preparation of Annual and Perspective Plan for the district
- Suggesting district specific interventions
- Carrying out survey of non-government providers and coordinate their contributions
- Partnership with NGOs, Panchayats for effective action
- Strengthening training institutions for ANMs/Nurses, etc.
- Provide leadership to village, Gram Panchayat, Cluster and Block level teams
- Establish Resource Group for Professionals to facilitate implementation of core strategies of the Mission
- Experiment with risk pooling for hospitalization
- Ensure referral chain and timely disbursement of all claims
- Arrange for technical support to the block teams and for itself
- Arrange for epidemiological studies and operational research to guide district level planning
- Nurture community processes
- Transparent systems of procurement and accountability
- Activate women's groups, adolescent girls' to ensure gender sensitive approach
- Provide data analysis and compilation facility in order to meet regular MIS needs
- Carry out Health Facility Surveys and supervision of household surveys

In order to facilitate proper planning and monitoring of activities of NRHM within a district, a District Health Monitoring and Planning Committee has been constituted with the following roles and responsibilities:

- Discussion on the reports of the PHC health committees
- Financial reporting and stream lining flow of resources
- Infrastructure, medicine and health personnel related information and necessary steps required to correct the discrepancies

- Progress report of the PHCs emphasizing the information on referrals utilization of the services, quality of care etc.
- Contribute to development of the District Health Plan, based on an assessment of the situation and priorities for the district. This would be based on inputs from representatives of PHC health committees, community based organizations and NGOs
- Ensuring proper functioning of the Hospital Management Committees
- Discussion on circulars, decisions or policy level changes done at the state level; deciding about their relevance for the district situation
- Taking cognizance of the reported cases of the denial of health care and ensuring proper redressal

The District Health Monitoring and Planning Committee will have the following brand pattern of representation:-

- 30% members should be representatives of the Zilla Parishad (convener and members of its Health Committee)
- 25% members should be district health officials, including the District Health Officer/Chief Medical Officer and Civil Surgeon or officials of parallel designation, along with representatives of the District Health planning team including management professionals
- 15% members should be non-officials representatives of block committees, with annual rotation to enable successive representation from all blocks
- 20% members should be representatives from NGOs/CBOs and People's organizations working on Health rights and regularly involved in facilitating community based monitoring at other levels (PHC/Block) in the district
- 10% members should be representatives of Hospital Management Committees in the district

For managing the day to day functioning of the Rogi Kalyan Samiti, Executive Committee has been given certain powers. The composition of Executive Body is as following:-

Executive Body:

- | | | |
|---|---|-------------|
| * | Collector | Chairperson |
| * | Chief Medical Health Officer | Members |
| * | Two senior medical officers out of which one should preferably be a lady doctor | Members |

| | | |
|---|---|------------------|
| * | District Programme Officer, Dept of Women and Child Development | Members |
| * | Executive Engineer, Public Works Dept | Members |
| * | Commissioner/Chief Municipal Officer, Municipal Corporation/Committee | Members |
| * | One Donor (with donation minimum 100,000/-) (in case of multiple donor who has donated Maximum will be nominated as member) | Members |
| * | One person from NGO/Rotary/Lions | Members |
| * | One Social worker (with proven track record in health) nominated by Exec Committee & ratified by General Body | Members |
| * | Hospital Administrator/Manager | Members |
| * | Civil Surgeon | Member Secretary |

The collector is mandated to chair the meetings. In his absence, the CMHO presides over the proceedings. The Executive Body will meet at least once every quarter.

General Body

| | | |
|---|---|-----------------|
| * | In-Charge Minister of the District | Chairman |
| * | Member of Parliament, Lok Sabha | Member |
| * | MP from Rajya Sabha (will self-nominate) to any one district | Member |
| * | All MLAs of the district | Member |
| * | President Jila Panchayat | Member |
| * | Mayor of Municipal Corporation/President of Municipality/Members Urban Local Body | Member |
| * | Collector | Member |
| * | Chief Medical Health Officer | Member |
| * | CEO, Zila Panchayat | Member |
| * | Executive Engineer, Public Works Dept | Member |
| * | Divisional Engineer, Madhya Pradesh State Electricity Board | Member |
| * | President, Indian Medical Association | Member |
| * | One Donor (with donation of Rs.1,00,000/-) | Member |

(in case of multiple donors one who has donated
Maximum will be nominated as member)

- | | | |
|---|---|------------------|
| * | Two social workers (suggested by the Executive Committee, ratified by the Chair) | Members |
| * | Representative of press to be nominated by the Press Club of the district | Members |
| * | District Public Relations Officer | Member |
| * | Civil surgeon cum Hospital Superintendent | Member Secretary |

ANNEXURE 4

Zila Panchayats vis-à-vis Health Care

Subject to the provisions of this Act and rules made thereunder and subject to policy directions, instructions, general or special orders as may be issued by the State Government from time to time, it shall be duty of Zila Panchayat to, -

- (i) prepare annual health care and safety plans of the district and to ensure the co-ordinated implementation of such plans;
- (ii) prepare annual plans in respect of the health care and safety schemes entrusted to it by the law and those assigned to it by the Central or State Government;
- (iii) co-ordinate, evaluate, and monitor health care and safety activities and guide the Janpad Panchayat and Gram Panchayat;
- (iv) ensure overall supervision, co-ordination and consolidations of the health care and safety plans prepared by the Janpad Panchayat;
- (v) ensure the execution of schemes, works, projects entrusted to it by any law and those assigned to it by the Central or State Government;
- (vi) ensure the execution of transferred or delegated functions, works, scheme and projects of the Central or State Government;
- (vii) reallocate to Janpad Panchayat and Gram Panchayats the funds made available by Central or State Government pertaining to the transferred functions, works schemes and projects, as per the norms fixed by the Central or State Government;
- (viii) co-ordinate the proposals for grants for any special purpose received from the Janpad Panchayat and forward them to the State Government;
- (ix) secure the execution of plans, projects, schemes or other works common to two or more Janpad Panchayats;
- (x) execute works, schemes and projects through Gram Panchayat or through the executing agencies transferred by the State Government to Panchayats, irrespective of their source of fund;
- (xi) advise the State Government in development activities protection of the environment, social forestry, family welfare, welfare of the disabled, destitute, women youth, children and weaker sections of the society;
- (xii) administer and control the employees appointed and posted in Panchayats including staff transferred by the State Government to the Panchayats like doctors and paramedical staff.

Zila Panchayats have thus vast powers and development functions without any ambiguity. Adequate care has also been taken to make budget provision to incur expenditure in the discharge of functions relating to public health and safety.

