MADHYA PRADESH

Madhya Pradesh was an amalgamation of the pre-independence Central Provinces. On November 1, 1956, the present state was reconstituted. At the time of its inception, it was a predominantly agricultural state with a very large tribal population. The major towns were Gwalior, Indore, Bhopal, Jabalpur and Raipur. The main function of these centres was administrative, military, trading or as junction-points on trade and communication routes. Pockets of industrial growth have emerged in Pithampur, Dewas, Malanpur, Mandideep and on the outskirts of most major towns. Madhya Pradesh has several regional variations. In geographical terms, it can be divided into the Malwa plateau, the Vindhyachal and Satpura ranges, the Sone-Narmada drainage region, the Bastar plateau and the Chhattisgarh plains. There is a clear divide in terms of agriculture between the rice-growing Chhattisgarh belt and the wheat-growing Malwa and Gondwana regions. The State of Chhattisgarh was carved out of Madhya Pradesh on November 1, 2000.

Madhya Pradesh has made remarkable progress in the fields of poverty eradication, control of disease, pestilence and famine, as well as in greater harvesting of its natural and industrial productive assets. However, considerable gaps remain. Madhya Pradesh has a total population of 60.4 million, the rural to urban ratio being approximately 73:27. Scheduled castes and scheduled tribes account for 15.4% and 19.9% respectively of the total population. The state is relatively sparsely populated with an average population density of 196/ sq.km. The state has made impressive advances in literacy in the last decade, with an increase from 44% in 1991 to 64% in 2001. Madhya Pradesh has 45 districts and hence an equal number of elected Zilla Panchayats (ZP). The urban sector falls under the purview of 334 urban local bodies.

Organisation of Health Care Services & Programmes[1]

Health care services in Madhya Pradesh are delivered by both public and private providers covering allopathy and Indian systems of Medicine and Homeopathy. The coverage and staffing of health facilities are determined by the norms laid down by the Government of India. In advent of decentralization, the district is the primary unit responsible for implementation of various programmes and delivery of health care services. As in other states, various national health programmes such as Tuberculosis, Malaria, Leprosy, Blindness and AIDS are being implemented in the state of Madhya Pradesh. However, in case of the RNTCP programme and Malaria control programme, an independent delivery structure has been established. In terms of assistance from bi-lateral and multi-lateral agencies, the Asian Development Bank (ADB) is currently supporting the GoMP with a Public Resource Management loan. Under the programme, earmarked resources totaling Rs 4.5 billion are provided for non-salary recurrent costs and for infrastructure investment in the health sector. It is expected that increased expenditure in health and social sectors will result from the reforms that are supported from this loan. The World Bank supports the implementation of the ICDS programme through the Department of Woman and Child Development. DANIDA has a state specific project and has had a long term involvement in the state through its Area Development Programmes. DANIDA is responsible for a significant share of all the primary health care infrastructure built in the State over the past 20 years.

[1] Govt. of Madhya Pradesh, Department of Health www.mp.nic.in/health/main.htm

It is currently focusing on key areas of systems development, training, IEC, drug and medical supply distribution, and the development of management capacity. The European Commission (EC) is supporting the state in the area of health care reforms. UNICEF and UNFPA provide support to the state through nationally agreed programmes. British aid is provided through the Department for International Development – DFID. In the short term, the focus of DFID programmes is to achieve a demonstrable impact on health outcomes by promoting a safer physical environment, behaviour change and better access to essential services. In the medium to long term it sees this as a means of addressing deeper systems issues through knowledge generation and dissemination, advocacy and programmes aimed at systems development and sector reform. DFID is also planning to provide support for public enterprise reform, decentralized government, rural livelihoods and public service delivery, including the provision of health services. The GoMP and the donors have now recognized the need to improve donor coordination to ensure that all donor-assisted programmes support a single, government defined health sector strategy.

Reform initiatives in Madhya Pradesh include[2-3]

In the arena of health, as all indicators and data show, Madhya Pradesh has a very long way to go. There exist constraints of a difficult terrain, poor availability of funds in a backward and poor region, lack of medical personnel to adequately service the population, coupled with an under nourished and weak population. With no options to enhance funding in health, a need was felt for change in the delivery systems and strategies in the state. To overcome some of these constraints, the State Government has undertaken some reform initiatives

(I) Decentralization

A. Initiatives in Decentralization

Madhya Pradesh emerged as a leader in decentralized development in the mid-1990s. It was the first state in India to hold elections after the 73rd amendment and to pass its own Decentralization Act. The GoMP strategy to deepen decentralization reform is based on: (1) community empowerment by strengthening village level institutions such as the Gram Sabha; (2) untied grants to the Gram Panchayat (GP) level; (3) improved accountability mechanisms, namely by establishing the people's right to recall local elected officials; and (4) devolving state government powers to Zilla Sarkar (District Planning Committee).

Madhya Pradesh has incorporated provisions of Article 243 of the Constitution through Madhya Pradesh Panchayat Raj and Gram Swaraj Adhiniyam, 1993 for rural areas. According to the Panchyati Raj Act of 1993, the state officially transferred authority and responsibility for policy making and programme implementation in 18 sectors[i], including health to the Zila Panchayat. Urban areas are addressed through Madhya Pradesh Municipalities Act, 1961 and Municipal Corporation Act, 1956, the former for Nagar Panchayats and Municipal Councils and the latter for Municipal Corporations. These acts together with various

[2] Govt. of Madhya Pradesh (undated), "Best Practices in the health sector – Madhya Pradesh", A note, Directorate of Health Services, GoMP.

[3] DoHFW, GoMP (2002), "Medium Term Health Sector Strategy and Situation Analysis, PART 2, Situation Analysis: The Health Sector in Madhya Pradesh", Submitted to the State Department of Health and Family Welfare, Government of Madhya Pradesh by HLSP Consulting Ltd & Management Services Group, June 2002

rules cover various aspects of the functioning of local bodies including constitution, elections, conduct of business, functions, and powers. The Constitutional stipulation of a District Planning Committee (DPC) has been given effect through MP Zila Yojana Adhiniyam, 1995 and its subsequent amendments. However, some of the financial and administrative powers earlier given to the DPC between 1998 to 2000 have been withdrawn and vested with the local bodies or the departments.

Under the M.P. District Planning Committee Act, 1995 and Amendment Act 1999 (Zila Yojana Samiti Adhiniyam), the government has created an institutional framework for district level planning and implementation of all development works.The main objectives/functions of the DPC are to formulate a consolidated development plan for the district prepared by the Panchayats and municipalities in the district, based on local problems/ issues which have been duly assessed by local bodies, as well as to identify local needs and objectives through a district level mapping of resources. It has the power to allot funds available through sectoral programmes within the purview of the DPC and to monitor progress of the plan activities. The DPC has been given powers to provide administrative sanctions for tenders upto Rs 1 crore (subject to certain conditions) and to transfer certain categories of employees (other than Class I officers) within the district. The DPC can also determine allocation of funds within certain sectors. Typically the DPC meets once a month, essentially to approve tenders, review progress on implementation of schemes and facilitate coordination across sectors.

In terms of composition, the DPC is essentially a political body with 80% of its members chosen by and from amongst the members of Zila Panchayat (ZP) and Municipalities in the District in accordance with the rural to urban population ratio. Special members include ZP Head, Minister nominated by the State, who will also act as the Chairman and one nominee by the State. The DC, as Secretary of the DPC is responsible for facilitating meetings of the DPC, preparing records of discussions and communication of all decisions.

On 26th January 2001, the GoMP introduced Gram Swaraj system with a view to further strengthen decentralization. This required that Gram Sabhas are established in every village and have the responsibility for administration of programmes at the village level. The key features relevant to integration of health, water and sanitation and woman and child development services are as under:

- As per the amended Act, the responsibility for provision of health, water and sanitation services was shifted to the Gram Sabha or general body of a revenue or forest village (average population of 600 in MP). The Gram Sabha also has a "Village Fund" with receipts from State/Central schemes, taxes, land revenue and income that the Gram Sabha may raise from other sources.

- The ZP, Janpad Panchayat (JP), GP and Gram Sabha can set up standing committees in order to plan and effectively manage their functions. The Gram Sabha and GP have provisions for constitution of Standing Committees for "Health" and "Education, health and social welfare" respectively. The State Cabinet in a recent review of the functioning of these standing committees has take a decision to have only two com-

mittees in place of earlier eight committees. These new Committee) will look after the functions of all the previous committees.[ii]

- The main functions of the Gram Panchayat include preparation of Annual Development Plans, execution of schemes/works/projects routed through the GP by Central or State government. In order to execute this role, it is provided with grants and a share of state levied taxes and fees. In addition, the GP may levy user charges for services provided by it as well as levy certain taxes.

- The role of the JP is to prepare the annual plans for economic development and social justice (based on plans prepared by GPs).

- The Zilla Panchayat has control over all rural development departments in the district. Its key functions include preparation of annual plans and ensuring co- ordinated implementation of these plans, and evaluation and monitoring the functioning of JPs and GPs in the district.

Hence, Madhya Pradesh has gradually been increasing the involvement of local governments in implementing social sector programs. Decentralization over the years has become the overarching policy framework in the state's vision for development.

B. Extension of Mission Mode to Health Sector – The Rajiv Gandhi Mission on Community Health[4]

The Rajiv Gandhi (RG) Missions were started on 20 August 1994 to address selected goals identified as priorities by the state government. Through these missions, the government sort to unlock the physical and human potential of the state by attending to some selected tasks with a sense of urgency. With this view, four missions were established, viz. RG Shiksha Mission, RG Watershed Mission, RG Food Security Mission and the RG Mission on Community Health. The Missions crafted a model that worked through participatory structures, which generated collective action as well as altered institutional arrangements within the government to generate inter-sectoral action around the identified Mission goals.

The Mission on Community Health which began in 2001 is an effort to rework the public health delivery model from below using the structure of political decentralization. It has recast the model of health action to include action within the health sector and parallel action on key determinants of health like safe water supply, sanitation, nutrition and hygiene education. By building in the public health agenda into an inter-sectoral framework at the district and below-district-level institutions (i.e. into the District Planning Committee to the Village Swastya Samiti), the Mission seeks to create a decentralized model of health care delivery. To do this and to also place the delivery of selected services in a rights-based framework, the Mission has created a Swastya Jeevan Sewa Guarantee Yojana (Health Services Guarantee Scheme) which includes creation of two community health activists in each village, one trained bare foot doctor or Jan Swastya Rakshak (JSR) and another trained dai or birth attendant (TBA) who along with the Angandwadi worker, will serve as effective bridges between the community and the nearest unit of public health delivery. New institutional arrangements like a State Health & District Health

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[4] Rajiv Gandhi Missions: Eight Years 1994 – 2002, Report To The People, www.mpindustry.mp.nic.in

Society have been established to plan and implement action for health in an inter-sectoral manner.

A) Swasth Jeevan Sewa Guarantee Yojana (SJSGY)

The Swasth Jeevan Sewa Guarantee Yojana is being implemented since July 2001. It is envisaged that the implementation of the SJSGY will lead to increased control by the community in the management of basic health care, creation of community level skills in basic health care and disease prevention, effective management and utilization of current resources and facilities and augmentation of resources to meet health-related tasks. It also seeks to identify a set of services within the health sector and some key determinants of health like safe drinking water, sanitation and nutrition to be provided within a rights-based framework of a guarantee by the government, which is operationalised at the district, panchayat and village level.

These services include:

- Providing a trained Jan Swasthya Rakshak in every village
- Providing a trained birth attendant in every village.
- Provision of Universal Immunisation.
- Three ante-natal checks for pregnant women.
- Provision of safe drinking water supply.
- Provision of nutrition cover to infants, children aged less than 3, pregnant and lactating women.
- Proper sanitation facility for solid waste management and waste water disposal.

Under SJSGY district-level programme has been put in place for health, built on the basis of collective problem definition through a Peoples' Health Survey which in turn forms the basis of a Village Health Register. Village-level health indicators contained in the Village Health Register when aggregated form the District Community Health Action Plan.

In terms of implementation, the district level institutional arrangement is headed by the Chairperson of the District Government. An implementation committee under the District Collector with the District Health Official as convener has also been established. At the village level, the health committee or Gram Swasthya Samiti serves as the implementation agency. The Gram Sabha has the power to determine the number of members of the standing committee on health[5]. It is stipulated that the Health Committee under the Act elects a President, for a tenure of one year from amongst themselves. The Committee is also required to elect a Secretary by two-third majority, with the proviso that the resident Jan Swasthya Rakshak in the village shall be nominated as Secretary of the Health Committee.

i) Jan Swasthya Rakshak (JSR) and Trained Birth Attendant (TBA)

The Jan Swasthya Rakshak (JSR) Yojana was started on 19th November, 1995 with the dual objective of providing basic health services in the rural areas

[5] The number of members prescribed under the Act is 12 of which fifty percent of the members shall belong to Scheduled Castes, Scheduled Tribes and Other Backward Classes, two third of which shall be from Scheduled Castes, Scheduled Tribes and remaining one third from other Backward Classes. The standing committee on health shall have at least one-third women members.

through trained personnel who can treat minor ailments and with the intent of developing a cadre of people to assist in the implementation of national health programmes. It is proposed that the presence of one JSR is ensured per village excepting those villages where formal health institutions (Sub Health Centre/ Primary Health Centre) are functioning. The JSR is selected by the GP/Gram Sabha and training is organized by SIHFW. The JSR is expected to provide health care in the village for which an appropriate fee is charged. A total of 41757 JSR were to be trained to provide one JSR in each village. Till date, however, more than this number i.e. 49,126 JSRs have been trained. This is because of the decision of the Government that one additional JSR should be provided in those villages where the tribal population is more than 50% of the total village population.

With an objective of filling in the information gap and to strengthen the programme, an independent evaluation of JSR was conducted. The evaluation brought out that the scheme is regarded to be conceptually sound and designed to meet a felt need. Issues like attrition rate in JSRs, the selection procedure, educational status of JSRs, need for better training aids, training management and training curricula, ensuring their link with the public health system and monitoring mechanism, were some of the issues raised. Based on the feedback received certain changes have been incorporated. For instance, it has been ensured that the Gram Sabha plays an active role in the selection of JSRs, the education criterion for JSRs has now been relaxed and preference is being given to candidates from SC and ST communities. The feedback on improving training management, curriculum and its design has been incorporated into the training now being given to JSRs. The evaluation report mentions that "redesigning the scheme with educated involvement of users, analysis of processes, better support systems, and slower pace could provide a viable option for village level primary care. Also there is a need to institute controls including control by users, better training, continuing education and concerted effort on National/ State Health Programmes." Most of these recommendations have been put into effect under the overall umbrella of the SJSGY[6]

Along with JSRs, the State Government has also decided to ensure at least one TBA for each village as part of the Swastya Jeevan Sewa Guarantee Yojana. Of the 52,317 inhabited villages in the State, till date 51,619 TBAs have been trained thus ensuring one TBA in all the villages with a few exception where women are not available for training / two or more small villages have been provided with one TBA.The main objectives of the dai programme is to provide ANC checkups, identify high risk pregnancies and counseling on nutrition and safe delivery; to conduct safe deliveries; to identify danger signs during delivery and appropriate timely referral. So far, 41,928 dais have been trained and another 1466 are under going training.

ii) Development of a Village Health Register and a Village Health Plan

As a village forms the basic unit of planning, needs assessment is undertaken at the village level through a village health register and a health plan is developed. This in turn leads to the development of a district health plan. An attempt was made at putting together a

[6] Govt. of Madhya Pradesh, "Madhya Pradesh Human Development Report 2002', Govt. of Madhya Pradesh

comprehensive data base on the health status of each village through the Peoples Health Survey or the Lok Sampark Abhiyan on Health. This survey helped to capture information on the status of health, health provision and status of determinant services. The information collected was put together in the Village Health Register.[7] The village health registers in turn are utilized to support a plan for Community Health. If required, additional resources are made available through a District Community Health Action Fund, implemented through the system of Gram Swaraj.

To sum, the Mission on Community Health is relatively new. Its larger objective is to strengthen district-level management of health care, create concerted action on health and its determinants and build action for health from below through community health activists. The various missions have benefited from the process of decentralization in the state, they have helped to deepen it and in turn are nourished by it. One of the lessons has been the necessity of developing state specific responses and strategies to address emerging health and development challenges.

B) Constitution of State Health Society & District Health Societies

As a part of the Rajiv Gandhi Mission, the State has constituted a State Health Society under the Chairmanship of the Chief Minister. The aims of this society include providing direction to the health sector; enabling integrated management of all National and Family Welfare Programme; facilitating the implementation of all or any of the programmes / projects supported by external agencies, overseeing the implementation of health policies, development and dissemination of IEC, promoting the involvement of the NGO, voluntary and private sector in health and related programmes, co-ordinating and strengthening disease surveillance, provision of technical support, review and co-ordination of Rogi Kalyan Samiti (RKS) set up for various state level institutions, amongst others.

The by-laws of the society stipulate the composition of the general body, criteria for membership and conditions for termination of membership, the rights, powers and duties accorded to the General Body, the nature of meetings to be held, including the minimum quorum. Similar guidelines are laid down for the functioning of the Executive Committee. The General Body consists of the Chief Minister as the Chairperson, with the Principal Secretary Public Health & Family Welfare acting as the Member Secretary.[8] Commissioner Health and Commissioner Family Welfare are the Joint Member Secretaries, while other members include Director Public Health, Director Medical Services, Mission coordinator RG Missions and two eminent persons in the field of health, nominated by the Chairman.

Similarly, District Health Societies have been constituted in each district for decentralized and convergent planning, resource pooling, implementation and monitoring of health programs at the district level. The District Health Committee is chaired by the Collector and the CMHO is its Secretary. The Committee also includes district officials of Department of Public Health Engineering who

[7] Village Health Register includes information on JSR, Dai, immunisation, ANC, Family Welfare, Malnutrition, Availability of Safe Drinking Water, Service Providers, VHC, Depot Holder, 4 Vital Registrations.

[8] The other members include, Ministers from Department of Health & Family Welfare and Department of Medical Education, Chief Secretary, Principal Secretary from Departments of Finance, Women & Child Development, Public Health Engineeing, Panchayat & Rural Development, Tribal Welfare, Medical Education, School Education, Forest and Public Relations.

look after drinking water and sanitation and Department of Women and Child development, who look after nutrition and women empowerment. Chief Executive Officer, Zila Panchayat is also a member. The District Health Society replaces different societies e.g. District RCH Society, District Leprosy Society, District TB Society, District Aids Control Society etc. so that there is better coordination of activities and rational fund use.

(II) Reforms related to Human Resources

A. Appointment of staff on contractual basis & provision of incentives

While many vacancies exist in rural areas, medical officers are inclined to get their positing in the urban areas. Hence, in order to ensure adequate doctors, the state government has made provision for contractual appointment of medical doctors by framing M.P. Public Health & FW Medical Cadre Contract Service Rules 2002. This initiative has various benefits as it ensures that rural posts are filled quickly. Furthermore, these appointments are done for specific place and for a specific period. Moreover, attractive remuneration is given to the doctors so as to ensure that they work in the rural areas. Under these contract rules, retired MOs who are medically fit are also taken up for service up to the age of 65 years. Currently, the state government is providing incentive to those doctors who have completed three years of service by regularizing them.

B. Course on Midwifery – The Obstetric Care Provider

The State has initiated moves to institute a course on midwifery. A taskforce constituted for the purpose has proposed curriculum and the State is in the process of selecting an institution for running the course. These trained community based obstetric care providers (OCPs) shall have their rural jurisdiction duly defined. They would also charge for their services in accordance with the rates determine by the Gram Panchayats.

C. Integration of ISM Medical Officers for RCH Services

The State has decided to utilize the services of ISM Medical Officers for RCH services. A training module has been developed and 357 ISM medical officers (out of 1407) have been trained.

(III) Changes in Financing Methods

A. Establishment of Rogi Kalyan Samiti [10-11]

In the state of Madhya Pradesh, as in other states, traditionally the delivery of health care has been within the domain of public sector. However, the availability of funds has been grossly inadequate when compared to the requirement. The burgeoning increase in population has stretched the facilities in government run health institutions to the limits, thereby leading policy makers and people to explore avenues for joint ventures to deliver better health care. Parallely, during the last few decades, there have also been isolated efforts at involving the people in augmenting physical infrastructure in government health

[10]Rogi Kalyan Samiti website – www.rogikalyansamiti.com
[11] (Undated), “Rogi Kalyan Samiti: An Innovative Project for the management of public hospitals through community participation in the state of Madhya Pradesh”

institutions. These efforts, however, were based on personal commitment and initiative and therefore could not be sustained. Hence, a debate was put forth to develop a system of sustainable public-private partnership for improved health care in the government sector in Madhya Pradesh through the establishment of RKS

Following a successful experiment with RKS in cleaning and refurbishing of the Maharaja Yashwant Rao Hospital (MYH) at Indore, the state initiated a scheme for citizen involvement in the management of state hospitals and health centres and introduction of user charges. RKS have been formed in all 43 District Hospitals, 53 Civil Hospitals and 228 Community Health Centres. RKS are also functioning in 717 of the total 1194 Primary Health Centres in the State. During the year 2003-04, the collection of the RKS was Rs. 1183.52 lakhs while the expenditure was Rs. 553.69 lakhs.[12]

In terms of its genesis, the plague epidemic which occurred towards the end of 1994 in the town of Surat provided the impetus for this innovative project to improve the public health delivery system in the city of Indore. One of the first places where attention was focused by the then District Collector of Indore, Shri S.R. Mohanty was the MYH Hospital. After an elaborate public discussion on what ailed the system, every aspect and shortcoming of the system was thoroughly diagnosed. The formation and implementation of the concept was headed by the local administration with active support from the general public as well as the locally elected representatives. Furthermore, in response to an appeal made to the people of Indore, donations started pouring in. The 750 bed hospital, along with five other supporting hospitals located in the same campus, was stripped bare. Through a carefully calculated process of admissions and discharge, all the patients were shifted to 12 hospitals situated all over the town, both government and private. The hospital was evacuated, cleaned, refurbished and its facilities vastly improved before reopening it for public use. No government funds were used in the project, which cost a little over Rs. 45lakh. With a view to ensuring a permanency to these changes, it was decided, to

(a) Carry out a scientific reallocation of available space to improve efficiency

(b) Initiate redefinition of administrative responsibilities

(c) Introduce user charges in the hospital to strengthen the resource base

(d) Establish a management structure, known as the Rogi Kalyan Samiti to ensure permanency to the changes.

Around a year after the experiment at the MYH in Indore, the State Government directed other districts to take up similar projects. In the first year, a handful of districts, especially those close to medical colleges adopted the scheme. By 1997-98, almost all the districts in the state had adopted it. All the committees were authorized to levy user charges according to their local conditions while remaining within the broad parameters laid down by the government. After a review of the system in 1999, the government issued instructions that gave sweeping powers to the Samitis. The instructions expanded the objectives

[12]Directorate of Health Services, MP.

as well as the duties of the RKS.

The main objectives and activities of RKS include qualitatively improving the management of the hospitals with community participation, bringing about upgradation of the health institution and modernisation of health facilities, purchase of equipment for institution, ensuring discipline & monitor accountability, provision of assured ambulance services for emergencies and during accidents, establishment of a public private partnership for betterment of the institution, maintenance & expansion of hospital building, development of the unused extra land of the hospital for commercial purposes as per the guidelines of the state government, increasing community participation, organizing training & workshops for staff members, ensuring adequate and safe disposal of hospital wastes, arranging for good quality diet & drugs and stay arrangements for the relatives of the patients, ensuring equity through provision of free treatment to patients below poverty line as well as proper maintenance of the hospital, wards, beds, equipment, cleanliness of premises and monitoring and supervision of the National Health programmes and lastly obtaining donations in cash or kind from the public at large or obtaining loans from banks & financial institutions for development & up-gradation of medical facilities in hospitals.

The RKS is a registered society and has been set up in all medical colleges, district hospitals, and community health centres. It includes people's representative, health officials, local district officials, leading members of the community, representatives of the Indian Medical Association, members of the urban local bodies and Panchayati raj representative as well as leading donors as their members. The composition of the RKS seeks to combine government officials, political leaders, peoples' representatives, donors, professionals and leaders of the community. Rogi Kalyan Samiti at each level has constituted two bodies for its effective functioning, namely, the General Body (GB)[13] and the Executive Committee (EC)[14]. A similar structure and composition comprising of relatively junior officers as notified by the government is replicated for hospitals at the PHC and CHC level, as well as at the tehshil and block level wherein community health centers, civil hospitals and other hospitals are covered.

The General Body is responsible for policy decisions, which in turn would be implemented by Executive Committee. Further, it has the power to amend the objectives, membership and change the rules and regulations of the RKS, authorize the EC for implementation of its functions, delegate financial powers to the EC and approve financial proposals that are beyond the powers of the Executive Committee, review the financial accounts and grant budgetary approval. It is stipulated that the GB meets atleast twice a year; and that its quorum consists of 1/3rd of its members. The EC would implement the decisions taken by the GB, is required to perform its day to day functions, has to meet at least once in two months with a minimum quorum of 50% of its members. It has the authority to raise funds for

[13] The General Body at the district level as per government directives, has the Minister in-charge of the district as the Chairman, with the Chairman of the District Panchayat, the Mayor or Chairman of the Municipal body, the District Collector, the Superintendent of Police, the Chief Medical Officer, one member of the legislative assembly, one senior doctor, the CEO of the district panchayat as well as the municipal body function as members. Additionally, the Executive Engineer PWD, two donors, leaders of the community, Secretary of the Red Cross Society as well as President of the Indian Medical Association serve as members. The Civil Surgeon is the Member Secretary of the RKS at the district level.

[14] The Executive Committee at the district level is headed by the Collector, members include CEO Municipal body as well as CEO District Panchayat, CMO, one senior doctor, one donor and the civil surgeon are members of the Executive Committee.

activities approved by the General Body, including new construction, purchase of equipment, drugs and consumables amongst others; as well as to appoint staff on contractual basis and levy user charges.

The RKS functions mostly as an NGO, has the freedom to determine the quantum of user charges to be levied. Charges are levied for all facilities provided in the hospital including the outdoor patient ticket, pathological tests, indoor beds, specialized treatment and operation amongst others. The Society raises additional funds through donations, loans from financial institutions, grants from government as well as other donor agencies. It also manages and has taken over the management of canteens, rest houses, stands, ambulance services and other facilities within the hospital complex. They allow private organizations offering high tech services like Pathology, MRI, CAT Scan, sonography to set up their units within the hospital premises in return for providing their services at a rate fixed by the RKS. The funds received by the RKS are not deposited in the state exchequer but are available to the executive committee constituted by the RKS.

Each RKS is free to utilize the funds as per its own judgement. The broad guidelines indicate that the funds could be utilized for ensuring regular maintenance, repairs and necessary construction/expansion of the physical facilities in the hospitals; ensuring cleaning, security, hospital waste management, MIS and other services of the hospital through private agencies; providing improved facilities by addition or upgradation of OT complexes; sonography, burn unit; ICCU; pediatric; CAT-scan units; centralized pathological set up amongst others; purchase of equipment, chemicals, furniture and other necessities for efficient running of the hospitalsfurthermore the funds are used for providing improved medical facilities through purchase of modern equipment through the donation received and if required through loans from financial institutions; provision of a better atmosphere, facilities for attendants and ensuring improved medical facilities in general; introduction of appropriate methods of disposal of medical waste and provision of medical care to the poor and needy (e.g persons living below the poverty line, freedom fighters) free of cost on self certification, or to others highly subsidized rates as compared to private hospitals.

In terms of successes and challenges, RKS has now been set up in all the district hospitals and other health institutions in the state. As fallout of the RKS experience, medical colleges have been granted autonomy and their management has been handed over to the RKS. The establishment of such society has led to an increasing sense of involvement of the community in management of its own affairs and enabled th em to contribute towards the strengthening of public institutions, brought about improvement in the efficiency of the doctors, helped stem the deterioration in public institutions and enhanced the credibility of the public institutions and led to an increase in the number of patients coming to government hospitals after introduction of user charges. The gradual introduction of user charges for the various ancillary services has ensured availability of services to people at a low cost. Further, there have been almost no protests in the entire state over the introduction of user charges. Some of the challenges which remain include, further developing the RKS in urban areas as well as

focusing on rural areas, ensuring the development of need based planning for the future, capacity building and training of its members, improving the work environment to bring about optimal performance, networking of the centres, issues pertaining to human resource development, development of a strong monitoring system and evaluation of performance, establishing linkages between grants, external financial assistance and borrowing and developing feedback as well as regulatory mechanisms so as to ensure delivery of services at an economical cost to the community. A few lessons learnt bring out the criticality of ensuring regular maintenance and upkeep, beyond the creation of such institutions, the need to regularly review performance, essentiality of ensuring the participation of the public in management of programmes and institutions. While, there has been success in creating a decentralized system, question remains as to how the institutional mechanism of RKS will ensure its sustainability and at the same time meet the health needs of the community.

(IV) Re-organization and re-structuring of existing system

A. Revision of Building Construction Rules

The State of Madhya Pradesh has been plagued by problems relating to lack of adequate health infrastructure. Hence, with a view to address these issues, the following amendments were made to the building construction rules.

- Administrative approval for civil construction up to Rs. 20 lakh can be issued by district health committee (on the condition that the State government has made provision in the budget),
- Decisions pertaining to civil construction upto Rs.20 lakh can be made by the District Health Committees through State PWD/ Housing Board/ Development Authorities.
- The Rogi Kalyan Samitis of district hospitals are competent to undertake civil works up to Rs. 10 lakh.
- The Rogi Kalyan Samiti of Civil Hospital can undertake civil works up to Rs. 5 lakh.
- The Rogi Kalyan Samitis of CHCs & Block level PHCs can undertake civil works up to Rs. 3 lakh.
- The Rogi Kalyan Samitis of Sector PHCs can undertake civil works up to Rs. 2 lakh.
- The construction of sub-health centres up to Rs. 5 lakh can be done by Village Panchayats.

B. Effective Operationalisation of First Referrral Units

The GoMP has initiated development of facility - specific operationalisation plans for all FRUs in the State under the aegis of District health societies. The implementation of operationalisation plans is underway.

(V) Other Policy Initiatives

A. Development of State level policies

The State of Madhya Pradesh has formulated various state policies. These include the Madhya Pradesh Population Policy, Women's Policy, Nutrition Policy and Draft Drugs and Medical Supplies Policy.

The MP Population Policy sets out specific targets for replacement level fertility, IMR and MMR to be achieved by 2011. It seeks to increase the involvement of PRIs, private sector and NGOs to promote people's participation in population stabilisation efforts as well to reorganise management and administration of the family welfare programme to make it efficient. The State Policy on Women formulated in 1995 included goals and action points in different areas of concern. In the realm of health, it reiterated the commitment of the GoMP to improve the physical well-being and survival of women and further listed fifteen action points towards this end. As the earlier policy had set targets to be achieved by 2000, a review was conducted and presently efforts are underway to formulate a new policy.

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[i] Rural Development, Health & Family Welfare, Fisheries, Public health engineering, school education, social welfare, women & child development, agriculture, scheduled castes & scheduled tribe affairs, mineral resources, food & civil supplies, youth & sports, rural industries, dairy & livestock, revenue, social forestry & labour (Madhya Pradesh Panchayat Raj Act, 1993)

[ii] The ZP health committee formed under the PRIs in rural areas was responsible for procurement of medicines & supplies, management of para-medical and administrative staff in the district and disease surveillance amongst its other activities. Technical support to this committee was provided by the CMHO as an Additional CEO and meetings were held once a month. Health committees were required to be established at each level of PRI, namely JP Health Committee (JPHC) at the block level, Gram Panchayat Health Comm ittee (GPHC) at the community-cluster level and the Village Health Committee (VHC) at the community/village level. As part of the ULBs in urban areas, the Health Committee had two permanent health staff within the committee, namely the Health Officer and the Health Inspector. Activities of the health committees of ULBs include sanitation and IEC activities.