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Review Article

Study of constitution and working of Rogi Kalyan Samiti in various states: A Review based on the survey of Common Review Mission of MHFW

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Abstract

Maximum population of our country lives in rural areas but hospital facility provided for this population is less that means most of the health problems faced by rural community. Government of India launched National Rural Health Mission on 12th April 2005 to carry out necessary architectural corrections in the basic health care delivery system, for the improvement of health of the rural population. Under the NRHM, Rogi Kalyan Samiti has been formed in all health facilities in the country to provide information, feedback, recommendations on the processes and mechanisms of RKS to improve the overall quality of the health intervention. The present study has been envisaged with an intention to provide the constitution and functioning of Rogi Kalyan Samiti in various states and survey was done during the 2007 to 2011 with the help of common review mission of Ministry of Health and Family Welfare (MHFW), New Delhi.

Keywords: Rogi Kalyan Samiti (RKS), NRHM, Health infrastructure, SC, PHC, RH, SDH, PRIs

1. Introduction

Since independence, the country has created a vast public health infrastructure of Sub-centres (SC's), Public Health Centres (PHC's) and Community Health Centres (CHC's). There is also a large cadre of health care providers (Auxiliary Nurse Midwives, Male Health workers, Lady Health Visitors and Health Assistant Male). Yet, this vast infrastructure is able to cater to only 20% of the population, while 80% of healthcare needs are still being provided by the private sector; Rural India is suffering from a long-standing healthcare problem. Although more than 70% of its population lives in rural areas, but only 20% of the total hospital beds are located in rural area. Most of the health problems that people suffer in the rural community and in urban slums suffer are preventable and easily treatable.

In view of the above issues, the National Rural Health Mission (NRHM) has been launched by Government of India, on 12th April 2005 [1]. To carry out necessary architectural corrections in the basic health care delivery system, with a plan of action that includes a commitment to increase public expenditure on health. The NRHM [2] seeks to provide effective health care to the rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure. Under NRHM [1], multifarious activities have been initiated to strengthen the rural health care delivery system for the improvement of health of the rural population.

1.1 Genesis of the Rogi Kalyan Samiti (RKS)

Under the NRHM, one major strategic intervention is up gradation of the health facilities, so as to provide sustainable quality care with accountability and people's participation, along with total transparency. In view of this, a proper management structure, called Rogi Kalyan Samiti (RKS), has been formed in all health facilities in the country. This committee would be a registered society acts as a group of trusties for the health facilities to manage the affairs of the hospitals [3]. It consists of members from, Panchayat Raj Institutions (PRI'S), NGOs, Local elected representatives, Officials from Government sectors.

2. History of RKS

2.1 The Beginning: The Indore Experiment

Maharaja Yashwantrao Hospital, Indore, is an institution that at one point of time was considered to be a premier institution for providing medical services in the country. Ever since it was established in its present form in the year 1955, while there have been occasional moments of glory, the deterioration in the standard and condition of the hospital had been gradual but definite.

It was the plague scare in Surat in the month of 1994 that attracted the attention of a terrified city to the need to clean-up the M.Y. Hospital. In response to the plague scare, a meeting was organized by the District Administration with

important opinion leaders of the town to discuss the strategy to fight the crisis. While most people stressed the need to improve the cleanliness/civic amenities of the town, several persons drew attention to the appalling conditions of hygiene in the M.Y. Hospital. The fact that the hospital has become home to thousands of rats, many of whom had become enormous in size, added a degree of urgency to the need to eradicate the rodents and clean-up M.Y. Hospital. In addition, the need was felt to repair the building and effect an overall improvement of the hospital as part of a comprehensive package to ensure a kind of metamorphosis to this premier institution of the State [5].

The district administration under the leadership of the collector took up the task. The task had to be performed quickly, with people's participation and with total transparency. In response to an appeal made to the people of Indore, donations started pouring in. In the first week itself, more than one million rupees were collected. 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 govt. and private. At the same time the entire complex was cleaned, thus removing tons of rubbish, truckloads of junk furniture and elimination of rodents, pests and insects. The eradication of rodents was one of the most difficult and hazardous tasks undertaken in the entire project. This involved de weeding, external and internal baiting, sealing of the entire sewage system, completely sealing the seven storied high mammoth hospital and finally using poisonous gas to kill the rodents, before disposing them off in an electronic crematorium [5].

About 150 truckloads of garbage was removed from the hospital and incinerated. The junked furniture removed from the hospital covered a mini stadium. After the clean-up, all physical facilities were restored and the hospital renovated to a state better than ever before. Throughout the entire process, the team persisted with the system of involving the people of the town in drawing up the policy framework for every stage of the operation. The team had a general apprehension that unless a system was evolved for ensuring a degree of permanency to these changes then despite our best efforts the hospital may lapse back into its old state of decadence in no time. As a result it was decided to take steps to ensure permanency to the improvements. With this objective in mind, it was decided to implement the following measures at the earliest.

Carry out a scientific reallocation of available space to improve efficiency Initiate redefinition of administrative responsibilities Introduce user charges in the hospital to strengthen the resource base. Establish a management structure that ensures permanency to the changes. This was called the Rogi Kalyan Samiti [6].

2.2 Common Review Mission-2007 Findings [7]

2.2.1 Assam

RKS and untied funds have worked as enablers at all the places visited; used for improvement of amenities; elected representatives involved; funds being used for emergency referrals as well. As per the state report, Assam Rogi kalyan samitis have been formed in all the places, i.e. in district hospital, CHCs and PHCs. As of April 2007,23 District Hospital RKS, 93 CHC level RKS and 610 PHC level RKS have formed and registered. However, in all the locations visited by the review team RKS was non-functional, existing only on paper.

2.2.2 Andhra Pradesh

Large scale use of untied funds at all levels; VH&SC, Sub Centres, Hospital Development Societies have received funds and utilized it; Sub Centre needs not taken care of as resources are given village wise; sanitation and cleanliness is the focus; wider public health activity likely to be taken up.

2.2.3 Bihar

Rogi Kalyan Samatis have been established in all hospitals and health centres and their impact is clearly visible in outsourcing of Ambulance services, uninterrupted electricity through Generators, dietary services, provision of Linen supplies, cleanliness services and environment. Services are generally of good quality. The untied funds were available at Medical College hospitals, District hospitals and 24x7 PHCs and have been used effectively for the above activities. Funds have reached and utilization has just started up to Block PHCs; need to speed up utilization to improve cleanliness and basic standards; need for stepping up of activity at Sub Centre and Additional PHC level; RKS guidelines prepared and disseminated; institutions need confidence to spend; electricity, ambulance, diet, and cleanliness through PPP.

As per the state report, Rogi Kalyan Samitis have been formed in all the places, i.e. in district hospital, CHC and PHC. As of April 2007, 5 District Hospital RKS, nine CHC level RKS and 32 PHC level RKS have been formed and registered.

2.2.4 Chhattisgarh

Untied funds utilized at all levels from sub centre, PHC, CHC etc. Jeevan Deep Societies playing positive role in hospital improvement need to give more confidence to these Societies for utilizing untied funds.

As per the state report, Rogi kalyan samitis have been formed in all the places, i.e. in district hospitals, CHCs and PHCs. As of April 2007, 16 District Hospital RKS, 128 CHC level RKS and 497 PHC level RKS have been formed and registered.

2.2.5 Gujarat

RKS at the level of hospitals and sub hospitals are well set; RKS at CHC level is one year old and teething problems are over; RKS at PHC not registered as yet in many

places; funds used for face lift of facilities; need to do more patient oriented services as well.

2.2.5 Himachal Pradesh

Himachal has RKS at District Hospitals level since 1999. Now Rogi kalyan samitis have been formed in all the places, i.e. in district hospitals, CHCs and PHCs. As of April 2007, 12 District Hospital RKS, 12 CHC level RKS and 2 PHC level RKS have been formed and registered. Promotion of stakeholders committee (RKS) for hospital management.

2.2.6 Jharkhand

Rogi Kalyan Samitis have been formed in all the places in Jharkhand i.e. in district hospitals, CHCs and PHCs. As of April 2007, 15 District Hospital RKS, 138 CHC level RKS and 179 PHC level RKS have been formed and registered.

2.2.7 Jammu & Kashmir

Hospital Development Boards from before, charging user fees; RKS formed at PHCs and funds received; process being completed in CHCs and District Hospitals; few facilities were yet to receive funds.

2.2.8 Madhya Pradesh

RKS are fully functional; evidence of substitution of State Government resources by RKS resources; needs immediate rectification; user fee collections form large part of RKS Budget; infrastructure maintenance, salary and medicine purchase are few items of expenditure; need to provision medicines from general hospital budgets; need to ensure that poor are not denied health care because of user charge. Rogi Kalyan Samitis have been formed in all the places, i.e. in district hospitals, CHCs and PHCs. As of April 2007, 48 District Hospital RKS, 267 CHC level RKS and 870 PHC level RKS have been formed and registered.

Public Private Partnership agenda under decentralization under NRHM in terms of constitution of Rogi Kalyan Samities at District Hospitals, Community Health Centres, and Block and Additional PHCs was also a priority agenda under NRHM registered Rogi Kalyan Samities have been reported to be functioning in almost all the DHs and CHCs in all the seven states. Interestingly the formation and constitution of registered RKSs has been reported to be working in majority of the PHCs. Village Health and Sanitation Committees (VHSCs) have been constituted and functioning in most of the villages in India.

2.2.9 Orissa

RKS set up everywhere but not effective everywhere as yet; works taken up to improve facilities; needs to make RKS realize their role and function.

2.2.10 Rajasthan

RKS established everywhere up to PHCs; raising revenues and also receiving untied grants, reasonable sums of discretionary funds are now available at institutions; while some have made good use, fear of incurring expenditure in others; Sub Centres have improved with untied funds; cashless hospitalization of BPL.

2.2.11 Tamil Nadu

Patient Welfare Society funds has led to marked improvement in the facility appearance and has considerably improved the look of the facility; development of gardens, gas stove connections, repair, RO (reverse osmosis) system for drinking water, inverter in labour room etc. done with untied funds.

2.2.12 Tripura

RKS have been established and have received untied funds and spending, mainly on facility renovation and purchase of needed instruments, furniture, etc. The spending of untied funds is in the range of 50 to 70%.RKS funds and untied funds very well utilized with complete involvement of Panchayati Raj Institutions.

2.2.13 Uttar Pradesh

Untied funds well utilized at Sub Centre level, improving the performance of the institution; RKS set up and beginning to use resources. There is a delayed utilization of RKS/untied funds due to delays in guidelines. Village Health and Sanitation Committees have been set up though getting the cooperation of PRIs is proving difficult in many areas. NRHM funds utilization has improved over the period at all level. Sub Centres and PHCs have started using untied grants under decentralization under NRHM. However, registered Rogi Kalyan Samities under decentralization scheme under NRHM have been constituted in all the 71 DHs, all the 515 CHCs, and in around 325 PHCs out of 3690 PHCs.

Capacity building or Skill Training for comprehensive Human Resource Plan necessitates strengthening of the existing training infrastructure. Hospital Maintenance or initiatives under PPP are still lacking in the state. Even peripheral services like cleaning, washing, catering, etc. have only been viewed to be outsourced to improve the services compared with appointment of regular staff for such services.

2.2.14 West Bengal

RKS formed in each and every institution up to PHC level, Panchayats fully involved, untied funds used very effectively to improve the quality of services, physical infrastructure handed over to Panchayats for maintenance, Panchayat Samiti involved in decision making.

2.3 Common Review Mission 2008 Findings [7]

2.3.1 Jharkhand

Most of the CHCs in Dhanbad, West-Singhbhum and Chatra don't have any emergency services for obstetric care, surgical interventions. Further, these CHCs don't have laboratory/diagnostic facilities like X-Ray, Ultrasound, and ECG facilities. Similarly regular positions of General Surgeon, Gynaecologist, and Paediatrician are also not filled up.

RKSs are functioning in 5 CHCs in districts of Ranchi and Chatra. Overall we find that CHCs in Ranchi out of all the districts are functioning better compared to other districts of Jharkhand.

Physical Infrastructure in the State comprises of 24 DHs, 194 CHCs, 330 PHCs, and 3958 SCs. However, 194 CHCs and have been upgraded to 24x7 basis since inception of NRHM. However, infrastructure strengthening under NRHM additionalities needs priority attention.

Human Resources shortage despite contractual appointments under NRHM additionalities of medical and para medical staff is still serious. There is serious shortage of specialists, doctors, and staff nurses in Jharkhand. Around 1710 general medical doctors have been recruited on contractual basis under NRHM. Under Communitization process under NRHM we find only 30011 registered VHSCs had been reported on the survey date with around 10,000 operational joint accounts. We have around 429 registered RKSs in all the health facilities in Jharkhand.

2.3.2 Orissa

Infrastructure in the State comprises 32 DHs, 231 CHCs, 1279 PHCs and 6688 SCs. need to strengthen the FRUs health facilities on priority basis. The health infrastructure in the State is getting upgraded. Some initiative in building renovation, adding facilities and procurement of drugs and supply to make up the critical gaps has been initiated but still there is urgent need for infrastructure upgradation.

Human Resource shortage in the State is still significant. There is serious shortage of human resource, especially doctors and staff nurses and paramedical staff at all levels. Still 46 PHCs are functioning without a doctor.

Contractual appointments under NRHM additionalities Communitization process under NRHM in the State seems to have picked up. Number of VHSCs in Orissa are 37078 with joint accounts of around 23302. Number of registered Rogi Kalyan Samities in Orissa is 481 with 32 in DHs, 231 in CHCs, 101 in Block PHCs and 117 in PHCs. Diagnostic facilities are reported to be missing in all the 10 CHCs. Even specialists/doctors are found to be not in position in most of the CHCs in all the five districts excepting availability of Obstetrician, and Paediatrician in both the CHCs of Puri viz. Nayahat and Chitana. Laboratory/Diagnostic facilities are totally absent in all the 10 CHCs as none of these have functional ECG, X-Ray and Ultrasound machines excepting Hari Chandan Pur in Kendujhar reports functional X-Ray machine. Availability of specialists/doctors like general surgeon, obstetrician, and paediatrician in regular positions are in-place in both CHCs only in Puri and Kendrapara. Overall availability of doctors seems to be better in Puri and Kendrapara. Functioning of Rogi Kalyan Samities is reported in all the 10 CHCs in Orissa.

2.3.3 Assam

Infrastructural facilities in Assam comprise of 22 DHs, 103 CHCs, 844 PHCs and 4592 SCs. Human Resources in Assam seems to be a serious snag. Out of requirement of 412 we find only 365 are in position and out of with 117 have been appointed on contractual basis under NRHM additionalities. Similarly we find around 178 Medical Doctors have been appointed on contractual basis under NRHM but still 61 PHCs are without doctors.

Decentralization process in the State is working well as Total number of VHSCs in Assam is 26816 with around 24085 with operational joint accounts. Number of registered Rogi Kalyan Samities is 987 with 22 in DHs, 108 in CHCs, 13 in Block PHCs and 844 in PHCs. Utilization of untied funds seems to have been improving over the recent past depicting that activities under NRHM have been getting strengthened.

Coming to specialists/doctors in regular position we find only in Darrang district we have general surgeon, physician as well as obstetrician/gynaecologist and in Chariduar of Sonitpur we have general surgeon as well as physician. Coming to laboratory/diagnostic facilities we find only one CHC viz. Dhekijuli in Sonitpur has reported functioning X-Ray machine and only one CHC viz. Naharani in Dibrugarh has reported functioning ultrasound machine. ECG machine is not available/ functioning in any of the 10 CHCs. However, referral transport services have been reported to be available in 7 out of 10 CHCs. Again we find all the 10 CHCs have reported functioning Rogi Kalyan Samities. Thus, overall we find that doctors, diagnostics services, and infrastructural facilities are somewhat better in CHCs in districts of Dibrugarh and Darrang.

2.3.4 Jammu & Kashmir (J&K)

Diagnostic facilities like ECG, X-Ray and Ultrasound machines are reported to be functioning in all the 10 CHCs under all the 5 District Hospitals. However, availability of key specialists/doctors like obstetrician/gynaecologist not in position in 4 out of 10 CHCs like Akhnoor in Jammu, Bhaderwah and Gandoh in Doda and Beerwah in Budgaon. Overall we find doctors in position are missing in Doda and Budgaon. Similarly Paediatricians in position are quite limited. AYUSH doctor in position is reported only in 1 out of 10 CHCs viz. Bisnah in Jammu. Referral transport is available in all the 10 CHCs. Thus, overall combination of key components of healthcare like positioning of doctors, lab-technicians, functioning diagnostic machines and referral transport; seems to be good in districts of Jammu, Baramulla and Udhampur.

Physical infrastructure in J&K comprises of 14 DHs, 85 CHCs, 375 PHCs, and 1907 SC. Decentralization process under NRHM seems to be working satisfactorily with number of, Number of VHSCs constituted are 6788 with around 5215 operational joint bank accounts. Number of registered Rogi Kalyan Samities (RKSs) was reported to be around 474 with 14 in DHs, 85 in CHCs, and 375 in PHCs.

Utilization of NRHM funds seems to have been picking over the years but yet full utilization of the funds has never been achieved since inception. Similarly utilization of

untied funds at different levels has also improved over the period.

2.3.5 Tamil Nadu

Availability of lab-test and functioning machines for diagnostic tests like ECG and Ultrasound machines is reported to be available in almost all the 10 CHCs excepting in Prandur of Kanchipuram district. Doctors/specialists in position is reported to be very poor in the state, obstetrician/gynaecologists, paediatricians and general surgeons are not available in any of the 10 CHCs. General Physician is available only in 1 CHC viz. Keeal Eral in Tuticorn.

Referral transport services are available in all the 10 CHCs and also AYUSH doctors are available in 8 out o 10 CHCs. Thus, overall doctors/ specialists in position at CHC level seems to be poor whereas diagnostic facilities, emergency services for obstetric care, referral transport services seems to be alright in most of the CHCs and relatively much better in districts of Madurai, Tuticorn, and Kanchipuram.

Physical infrastructure in TamilNadu comprises of 27 DHs, 206 CHCs, 1215 PHCs and 8706 SCs. In all 291 health facilities are functioning as FRUs comprising of 27 DHs, 133 SDHs and 131 CHCs.

Human Resources in the state comprises of 725 specialists or post-graduate doctors. There is no PHC without a doctor or GDMO and all the 1215 PHCs are having three staff nurses. We find around 15158 VHSCs are functional in around 16317 villages in the state. Number of registered RKSs was reported to be 1683, with 27 in DHs, 257 in CHCs, 234 in Block PHCs, and 1165 in PHCs.

Utilization of funds at SC and PHC level has been quite good. All the VHSCs have operational joint accounts in the state. Further we find that NRHM funds have almost been fully utilized in the state. Drug procurement and supply under NRHM seems to working very well in the state. All PHCs and SCs are provided with requisite drugs and other supplies.

2.3.6 Uttar Pradesh

In terms of Human resource situation we find that most of these CHCs are not having General Surgeon, Obstetrician/Gynaecologist and Paediatrician are not in position in most of these CHCs. Coming to diagnostic facilities we find that even X-Ray, ECG machines were not found functional. All the CHCs have reported constitution of Rogi Kalyan Samities. AYUSH doctor in position is reported only in on CHC at Panwari in Mahoba district. Overall availability of emergency health services, specialists, diagnostic facilities are better in Saharanpur, Mathura and Unnao.

2.3.7 Madhya Pradesh

None of the 12 CHCs in MP reported availability of functioning ECG and X-Ray machines under diagnostic facilities. Under human resource we find that situation is awful in the sense no Physician, no Paediatrician, no Anaesthetist, no Eye-surgeon is available in any of the 12 CHCs. Only General Surgeon is reported to be available in 2 CHCs of Katni district in 8 CHCs in 4 districts Neemach, Vidisha, Hoshangabad and Dhar. Still physical infrastructure in terms of good buildings with clean floors, pharmacies, functional labor rooms, is reported in most of the CHCs. All the 12 CHCs have reported constitution of RKSs. There is no AYUSH doctor in position at any of the 12 CHCs. Overall availability of emergency services, specialists/doctors and diagnostic facilities are better in Hoshangabad and Neemach in Madhya Pradesh. Inadequate capacity-building efforts and absence of a rational workforce policy also hampers quality of care. VHSC needs to get involved in the district health planning process and should not be restricted only to community monitoring.

Table 1: Table showing state-wise availability of facilities in 20 PHCs in common review mission 2008

SN	Facilities	State-wise availability of facilities in 20 PHCs (%)						
		Jharkhand	Orissa	Assam	J&K	Tamilnadu	Uttar Pradesh	Madhya Pradesh
1.	Functioning in own building	90	85	100	85	100	92	92
2.	Completed construction	55	80	85	25	90	71	75
3.	Drinking water facility	65	60	80	70	100	58	67
4.	Storage facility	65	5	70	70	85	58	67
5.	PHC pharmacy	85	95	100	90	100	96	NS
6.	Adequate medicine	60	50	60	50	95	88	NS
7.	OPD rooms	95	95	90	90	100	88	NS
8.	OPD services	100	100	100	100	NS	96	100
9.	IPD services	50	30	30	80	NS	63	71
10.	AYUSH services	10	75	30	NS	NS	38	25
11.	Monitoring and supervision	85	90	80	90	NS	65-85	100
12.	Collection and reporting of vital statistics	NS	20	45	100	NS	42	62
13	Rehabilitation services	NS	20	15	15	NS	NS	21

NS: Not Survey

2.4 Common Review Mission 2009 Findings [8]

2.4.1 Chhattisgarh

Jeevan Deep Samiti funds are being well utilized for providing free medicines, surgical aids to patients and improvements are visible. Infrastructure progress is improving – work completed on sanctioned civil works rose from decentralized action through various community participation strategies like Mitanin programme, Swasth Panchayat initiatives, preparation of Village plans have considerably improved community's participation in the health services.

There is a need to expedite the pace of trainings related to RCH such as SBA, IMNCI and multi -skilling. Placement of multi -skilled doctors in FRUs for managing complicated deliveries needs to be ensured. The training of the MOs in multi-skilling needs to be resumed. Infrastructure management cell/wing to be put in place, and expedite work further – 15% of civil works is yet to start. Huge shortage of human resources at various levels particularly in Medical and Specialist cadre. Total vacancy ranges from 7.5% for staff nurses to 65% in specialists cadre. Availability of key specialists/ doctors positions is affected by irrational distribution of HR. focus should be given to comprehensive assessment and planning for HR gaps including strengthening in-service training capacities:

In almost all the facilities visited, registered Rogi Kalyan Samiti (called as Jeevan Deep Samiti in Chhattisgarh) has been established and meetings have been conducted; however, these meetings are not regular and there is no time line followed.

RKS (Jeevan Deep Samiti) Funds: Minute Book of Jeewan Deep Samittee (RKS) was found to have been maintained. But meetings are not conducted regularly. Involvement of Panchayati Raj Institutions in Jeevan Deep Samities and VHSCs is very weak. Community representative are not aware of their roles.

2.4.2 Arunachal Pradesh

Facilities are well maintained and clean infrastructure including toilets with round the clock water available up to the sub-centre levels. Adequate equipment in the facilities visited.

Comprehensive Plan and institutional support for infrastructure development is required. Special drive and strategies needed for recruiting specialists, medical officers and nurses with higher salary/incentive, especially for hard to reach areas, quicker and more regular recruitment process (Medical Graduates/ANMs are available at least to fill some of the gaps) and linking PG seats to rural service bonds for serving in difficult terrain. Training of ANMs on SBA, IMNCI, NSSK, etc needs to be expedited. Clear guidelines needed for RKS and VHSCs, Need to strengthen mentoring by supervisors and monitors, if needed by establishing regional monitoring units. Improve Logistics and Supply Chain Management of drugs and put in place a comprehensive and sustainable plan for procurement of drugs and equipment. District office infrastructure and staff needed along with training of DPM, Data Manager, Finance Manager and Other Programme Managers on Monitoring with a checklist.

2.4.3 Assam

Substantial additions to workforce: contractual appointments of 1067 doctors, 2295 staff nurse, 698 paramedics, 921 ANMs & 117 specialists are positioned.

Design of infrastructure and utilization of infrastructure both need improvement. IUD insertion training to be provided to service providers who are manning the facilities. So far only doctors have the training. No clear HR policy to close gaps.

2.4.4 Jharkhand

State has initiated engineering wing at state level which takes care of all infrastructure development- related work under NRHM. Many facilities now have new buildings with residence for staff and more are under construction. Numbers of facilities are coming up with new buildings. Large number of contractual staff put in place under NRHM. Trainings related to RCH under NRHM are showing improvement in performance and quality of the services. Strong motivation, commitment and leadership at individual levels, vibrant and effective PMUs. State innovations are promising – e.g. Adolescent Week and Yuva Maitri Kendra, Family Friendly Week, Sahiyya Help Desks in DH/CHCs.

Progress of infrastructure construction needs further improvement. A comprehensive HR policy to be developed to close HR gaps over the coming years. Strengthen the existing mentoring and support network for Sahiyyas and there is need to enhance incentives for trainers at block and district level. Build up a strong management support function in the state-PMUs and include institutionalisation in next plan.

2.4.5 Kerala

Public Health Infrastructure show near adequacy – only few SDH gaps remain. Human resource gaps in sanctioned posts are minimal, except for specialists in CHCs. The Compulsory Rural Service has ensured regular yearly supply of MBBS doctors in rural areas. RKS well functional, with minutes recorded, and there were additional sub-committees for palliative care or the Rapid Response Team.

External evaluations for new interventions to optimize and scale up the strategy – in particular, palliative care, child development service and district-based non-communicable disease strategy. Systematic and consistent process in health services delivery is needed.

2.4.6 Madhya Pradesh

Infrastructure Development Wings established at state, division and district level. Good progress in constructions: 792 new constructions completed and another 717 in progress. Massive shortfall of all Health Sector providers being addressed by contractual staff (specialists, MOs, SNs, others like LHVs), extending retirement age to 65

years, extending recruitment pool to other states, differential remuneration for difficult areas for doctors and nurses have been initiated. In-service training for health providers is ongoing and needs to be followed by refresher sessions and suitable postings.

Critical HR gaps need to be addressed. 61% shortfall of specialists, over 50% of doctors at PHCs; 53% SN, 17-36% support staff like LTs, pharmacists etc. PRI involvement in RKS/HMS sub-optimal. Perception of RKS is as a fund-generation mechanism, not used for improving public participation or quality of care. Poor utilization of RKS funds persists.

2.4.7 Maharashtra

State has significant contribution to infrastructure improvement with new PHCs and sub-centres, labs, OPDs and wards construction. Infrastructure Development Wing functioning well. Initiatives taken up to improve availability of specialists like seats for PG, for MOs in service, withdrawing specialists deputed to Medical Colleges and ensuring hardship allowance for serving rural areas. Efforts to be taken to sustain skills of EMOC trained doctors where C-sections had not started up – through elective C-section opportunities. Currently Community-based monitoring is being implemented in five districts, encompassing 23 blocks and 510 villages.

Issues like lack of supportive staff for Engineers in the Infrastructure wing needs to be addressed to ensure that the momentum is maintained. Infrastructure planning/location needs to be linked, village micro planning/tagging of hard to reach areas with more rationalization. There is need for a good HR Policy especially for contractual appointments. Training plans for all skill-based training needs to be developed for every district. Financial Management capacity of facilities to use untied funds needs to be strengthened, grievance redressal mechanisms needed.

2.4.8 Nagaland

Health Institutions show high degree of sanitation, cleanliness and well maintained. Sanctioned civil works have been completed -for 56% facilities. State has filled 68% positions of skilled health providers (including specialists).

Despite increase in numbers of facilities, full functionality still an issue, especially bed occupancy rates, blood bank at DH and blood storage at FRUs, and availability of specialists/multi-skilled Medical Officers. Equipment should be quickly installed and staff trained. Pace of construction and renovation needs to be improved. Training programmes should be planned for Village health committees for engaging them in village health planning, community mobilization and monitoring.

2.4.9 Orissa

HR shortfall (only 30% doctors, 28% nurses are in place) addressed by:fast-track recruitment of contractual personnel. State level Infrastructure Development Wing is urgent necessity: 3 District HQ Hospitals haven't been built despite approval in 2008-09. Need to increase sanctioned posts – especially for staff nurses and medical officers. Need to put in place comprehensive strategy to attract and retain skilled professionals in rural areas as part of HR plan. Most of the gaps observed are related to managerial skills and quality issues. Capacity building with supervision and refresher sessions would be useful in resolving issues such as lack of conceptual clarity, M&E, documentation, problem-solving, quality issues, financial and program management.

2.4.10 Punjab

All infrastructure gaps would be closed by 2011. There are excellent institutional arrangements for infrastructure development. Considerable improvement quality of services delivered at facilities such as clean facilities with lab services; laundry services adequately managed and display of Citizen's charter, privacy for women assured. Good progress on filling in contractual staff positions.

Provision of diet and security in the facilities needs to be ensured. Progress on training of all other cadre is slow. Process for community monitoring needs to be established. Flow of resources to the district should be as projected in plan and not on line item basis. Facilities with greater volume and range of services would need more funds, especially if they cut back on user fees as recommended. Over all absorption of funds are weak largely as a result of poor guidelines and low areas of expenditure affecting the overall performance.

2.4.11 Rajasthan

Hospital development committee's were functions across all facilities and visible stakeholder's participation with fair understanding of functions, roles and responsibilities. Facilities are clean with adequate privacy arrangements. There were functional newborn corners and quality of care for institutional delivery was also improving. *Jan Aushadhi Kendra* – the novel scheme of promoting generic medicines were also present. 80% of the sanctioned posts on contract basis for AYUSH doctors and nursing staff was filled adding substantially to seal the HR gaps. Financial Management systems were much better functional and quarterly return formats, 100% filled till district level.

Under NRHM contractual positions there are major gaps in finding staff because of reluctance to work in difficult areas. So there is a need to address by mix of measures for attraction and retention of skilled professionals. The district and village planning still continues to be template-based despite huge amount of information available and budget allocation to district not as per PIP.

2.4.12 Tamil Nadu

Infrastructure gaps are almost closed and adequate for basic services to be delivered. Commitment of MOs/staff at health facilities are high and one interesting policy on HR in the state is AWW are eligible for ANM training. Electronic fund transfers are upto district level. However, certain area like Financial Management has been weak and needs

monitoring and supervision mainly in the areas of utilization of innovative funds.

Facilities in the state need improvement in infection control and clean environment including bio-medical waste management, residential accommodation and security for night duty staff. Provision of accountants at the facilities may help in financial management reform and in book keeping.

2.4.13 Uttarakhand

Multi -skilled doctors trained in EMOC and LSAS are functional and RKS was in place in most of the facilities. But there is a need of HR plan that would specify ways to increase recruitment of permanent staff, as well as rational, gender-sensitive and supportive policies to retain contractual staff. Along with this, there is a need to improve utilization of existing infrastructure.

2.4.14 Uttar Pradesh

Satisfactory progress in up gradation of public health infrastructure (out of 3692 PHCs,, 3187 are in Govt. buildings. Contractual posting and multi-skilling personnel have been adopted as strategies to reduce the gap in Human Resource. Programme structure of NRHM is well placed in the state and for effective supervision and efficient implementation of the programme; teams have been formed at block, district, division and state levels.

In state there is critical shortage and irrational deployment of HR and equipment. State needs to introduce some reforms to attract and retain its man power especially doctors. State budget for the up gradation of the public health infrastructure should be increased. Inadequate capacity-building efforts and absence of a rational workforce policy also hampers the quality of care. VHSC needs to get involved in the district health planning process and should not be restricted only to community monitoring, so there is a need of orientation.

2.5 Common Review Mission Findings 2010 [9]

2.5.1 Arunachal Pradesh

Monitoring mechanism is in place and team found adequate in RNTCP and NLEP but due to vacancies in other programmes monitoring is not satisfactory. There is lack of adequate supportive supervision and monitoring from the state level. RKS meeting held at irregular periodicity; participation of PRI members is found to be less. RKS, AMG untied funds, VHSC funds released from the district to the concerned institution on time. There is a significant increase in expenditure across quarters.

- Concurrent audit being done but the periodicity is irregular.
- The progress in program management is good (97%), BCC/IEC (62%) etc.
- All units are submitting Utilization Certificate and Statement of Expenditure except for the VHSC funds.

Plan documents are available but PRI involvement reported to be sub-optimal, apparently due to lack of interest on the part of the PRI members. 50% VHSCs have been formed although they have limited functionality. Community monitoring has not started and RKS funds flow has led to improved service delivery. Some Programme Officers were not aware of sections of district plan relevant to them.

2.5.2 Assam

Plan documents are available at the district level and salient points are communicated to block officials. Village level needs are only partially incorporated. VHSCs have been formed in all villages, with 1-day orientations for members.

PRI involvement could be strengthened.

- Untied funds received twice but expenditure pattern sub-optimal.
- RKS formed up to PHC level, but mostly non-functional.
- Community monitoring had been suspended for 2 years.
- PPP model is working well in Lakhimpur at Harmoti tea garden.
- Evening OPD, a good initiative. It is catering to the needs of the community and has more than 50% attendance of the morning OPD.
- The overall fund utilization in the state has improved especially with regard to RCH Flexi pool. Due to slow progress in fund absorption under NRHM Flexi Pool, overall utilization level is around (51%) 2010. Although the absorption of untied funds at various levels has improved, every year there are left over untied funds in most health facilities.

2.5.3 Bihar

The institutional set up is comparatively slow and need to be augmented. For the financial year 2008-09 State Health Mission meeting held twice and of District Health Mission 62 meeting have been held. There are no VHSCs in the State, Rogi Kalyan Samitis are operational at 26 DH, 51 CHCs & 389 PHCs. out of 38 districts 2 districts have started developing their own DHAP (district health action plan).

Rogi Kalyan Samitis formed in all health facilities till PHC level, registration of RKS completed in 513 of 653 RKS, are functional. Formation of VHSCs needs to be taken up on priority. Active involvement of RKS members in funds utilization & facility development is required. Under the Training component appreciably 85% amount is spent, but the impact of the training activities is not reflected on other components.

2.5.4 Chandigarh

Regular meetings of State Health Society were held regarding the monitoring & evaluation and monthly review and action taken. These meetings of Governing Body were attended by the Mayor, Municipal Corporation; Health Secretary; Finance Secretary; Secretary, Indian Red Cross Society; UT(union territory), Mission Director; Chief Engineer UT; and PA to Chairman, Zilla Parishad.

Rogi Kalyan Samiti funds are mostly used for supply of free drugs to the poor patient. Prior approval of RKS is taken for use of this fund. In deserving cases, ex-post facto approval is taken. PRI involvement in VHSC meetings is satisfactory. SPMU (state programme management unit) coordinates and supervises the activities of District level hospital. The procurement and logistics system is in place and

which is responsible for assessment of required inventory items, constituting the purchase committee and also constitution of an inspection team which approves the specification and quality.

2.5.5 Chhattisgarh

SPMU and DPMUs are generally in place and fifty percent of SPMU staffs are in position, one fourth of DPMU staff are in position and two thirds of block programme unit positions are lying vacant. Infrastructure for SPMU and DPMUs are reasonably good. Procurement of medicines is as per essential drug list. PRIs are members and part of JDSs (jeevan deep society); however, it was found during the visit that meetings are most often organized on the basis of needs of the BMO (block medical officer) or institution in-charge.

State has developed system for supervision and monitoring activities such as check-list for field visit, preparation of visit report, feedback system etc; though, frequency and intensity of visit varies across districts e.g. it was found in Raipur district but not in Surguja district. In bigger districts such as Surguja DPMU (district programme management unit) is not able to conduct various monitoring visits. The online system for monitoring developed by the state is at initial stage.

Rogi Kalyan Samitis have been renamed Jeevandeep samitis and have developed a charter of improving the quality of services in a measurable manner. The level of achievement is certified after external verification and stars of recognition and incentives are awarded to the best performing facilities.

The RKS of Chhattisgarh has been constituted with much thought, Of 716 PHCs, 662 are registered, and of these 28 have held meetings, and of 1CHCs all have RKS, and 112 have held meetings. District hospital RKS have all held meetings.

However the functioning of a number of RKS is below desired levels. The RKS approach is not without its problems. One of the most persistent problems with the RKS is the apparent reluctance for utilisation of funds, the lack of awareness or of delegation of powers.

2.5.6 Maharashtra

There are reports of a number of innovations which are worth assessing before a decision is taken on scaling-up the best of these. The innovations include: **Maher**– a birth waiting home model to promote institutional deliveries is working well in tribal areas of Gondia. The waiting room is adequately equipped with bathroom, solar heating with beds and food for each patient and one attendant. Promotion of breast feeding by provision of **Hirakani Chamber** in Kolhapur is worth assessing for scaling-up.

An innovation called **Silent Observor** to check misuse of ultrasound clinics for sex determination. Felicitation of mothers delivering a female child with a thermal set, baby kits, sarees and birth certificate through the Lakshmi **Aali Ghari scheme**. Solar panels are available in PHCs of remote areas.

Maharashtra has taken some good initiatives to address the issue of human resources. For availability of Medical Officers in PHCs the posts of MO are exempted from the purview of the Public Service Commission. The Regional Deputy Directors are also delegated powers to appoint Medical Officers temporarily as per need and vacancy. This has resulted in drastic reduction in vacancy of the MOs. Currently, 719 posts of Medical Officers are sanctioned out of which 619 (87%) posts are filled in. AYUSH doctors are employed at facilities from DH to PHC levels and most of the posts are filled.

To improve availability of specialists, Seats for Post Graduation have been reserved for MOs in service. The state plan for withdrawing specialists (from the Public Health Department) who have been deputed to Medical Colleges is a positive step. There are around 600 such specialists and the plan may be greatly instrumental in plugging the gaps for specialists for rural areas in the state. Hardship allowance is being given to medical officers and specialists. The quality of training is not optimal in certain areas. In Gondia district, training on use of partographs was not a part of the SBA training. This is a serious issue. There is lack of translation of skills into practice.

Trained staff nurses were not aware of the step by step procedure for neonatal resuscitation as observed in most facilities in Gondia District. Drug and Equipment Adequacy: Supplies appeared relatively adequate, but availability of essential medicines seemed to be quite inadequate in high-utilisation facilities including a rural hospital (CHC), a Sub-divisional hospital and a District hospital.

In DH Satara, poor planning, financial management and accounting of various flexible funds was seen. Large scale district level purchase of medicines and supplies have been made on behalf of RKS of PHCs and sub- centres in the district. VHSC funds are being spent on AWC up gradation and supplies for malnourished children and referral transport. ICDS funds could be preferred for this purpose. There is a distinct disparity in the cleanliness and general management seen between the PHC and hospitals.

2.5.7 Kerala

Management systems are established till the block level; the coordination between district, district health office and block level is good. RKS committees combine of the heads of health institutions and members of the PRI and voluntary organisations. District health missions are conducting meetings but not found to be regular.Supervisory schedules are not structured for facilities.

2.5.8 Madhya Pradesh

High level State health mission meeting was held which is chaired by Chief Minister of Madhya Pradesh. The meetings for The District Health Mission have increased over the years but this year's data shows that very few meetings

have been held. The Programme Management Unit structure by NRHM i.e SPMU, DPMUs, BPMUs are in place. Their role with the inter-disciplinary skills needs to be recognized and valued.

At state level, the Joint Directors were made in charge of the seven divisions in the state. Their role was mainly to monitor and supervise the functioning and performance of the various districts in their divisions. Also, trained staffs in SBA and IMNCI are not being monitored for the outcomes.

In Khargone district, there is an established system for supervision and monitoring activities. The reports are regularly checked and feedback given. However, in Damoh district, the monitoring and supervision was one of the weak areas.

2.5.9 Orissa

Supply Chain Management of drugs is weak. State has lack of comprehensive and sustainable plan for procurement of equipment. The extent of utilization through Rogi Kalyan Samiti is improved but variable. The expenditures are backed by formal decision with due consent from the PRI members. The supportive supervision activities of the PMU, needs to be strengthened for its capacity to supervise and assist the field workers on a regular basis. System for accreditation of private hospitals for Janani Suraksha Yojana, Maternal Health and Family Planning services has been established. Zilla Swasthya Samity: ZSS has worked well in mobilizing resources through convergence like NBC equipment from the RSBY fund.

2.5.10 Punjab

DPMUs are integrated with CHMO office and seamless integration will be strengthened if the new tasks are also managed adequately e.g. planning, logistics etc. A technical pool of seven persons at state level acts as the SHSRC. RKS meetings, about once in a quarter and its composition has PRI, professionals and NGOs. Only the NRHM RKS grant is brought under this purview. Private sector accreditation was weak. Only few facilities linked up to, though large numbers of private facilities are providing RCH services including delivery.

The Civil Hospital, Nabha has a RKS, however, it was not registered on the date of survey. The hospital did not charge for consultation/procedures under this Scheme. The RKS at Civil Hospital is entirely based on government grants and did not raise any additional fund either through donation or user fee or other innovative means such as private-public partnership (PPP), outsourcing of services, etc. there was no display board in the hospital showing number of members, number of meetings of RKS etc.

2.5.11 Rajasthan

RKS (Medical Relief Societies) are functional at all levels – PHCs, CHCs and District Hospital; but their role and nature of their participation has not been fully understood. Rajasthan has initiated steps to partially devolve financial and administrative authority of Health and Women Child Development department up to the district level to the PRIs. In a three tier format, the staff of the health and nutrition programmes at the district, block and village level will be accountable to the corresponding levels of PRIs, the Zilla Parishad, the Panchayat Samiti s and the Gram Panchayats. State has reasonably good involvement of PRIs in health-related activities.

2.5.12 Uttarakhand

No evidence of adequate use of available data for planning by PMUs. Roles and job responsibilities of DPMU/BPMU were not uniformly clear. Induction and refresher training were not being carried out systematically. The RKS institution appears to be in place in most of the facilities, the presence of PRI is significant. Untied funds have been used mostly for maintenance and infrastructure up gradation (furniture and fixtures).

2.5.13 Tamil Nadu

The Financial Management was weak. Report of concurrent audit is not being shared with facilities. Book-keeping is absent or poor. Proper monitoring and supervision of utilisation of innovative funds should be there.

2.5.14 Uttar Pradesh

There is huge shortage of finance manpower in the state. Out of 71 districts 21 positions of District Account Managers are vacant and positions of 01 block accountants out of 823 blocks are vacant. All the funds are disbursed through e-transfer up to the PHC level which is a good practice followed by the state. Concurrent Audit has been conducted and 30 districts have submitted their concurrent report for September 10 in 2010-11.

2.6 2011 Common Review Mission Findings [10]

2.6.1 Assam

There was a lack of separate toilets for male and female patients in most facilities in districts. Old sub-centre buildings do not have provision for stay of ANM. There is an acute shortage of inpatient beds for MCH care in District hospital. Signages generally in place and Citizen Charter and list of drugs are displayed in most of the facilities. All Rogi Kalyan Samiti (RKS) are not registered under Societies Act 1860. The payment of Audit fees and Audit expenses incurred against interest earned on NRHM Funds.

Rogi Kalyan Samities: The Hojai FRU, Dhing Block PHC, Doboka CHC, Simonabasti PHC, Kuwaritol PHC, Jakalabandhu FRU and the Jugijan PHC‘s records showed a utilization of 99%, 95%, 90%, 93%, 43%, 100% and 91% of RKS funds for the year respectively. The RKS meetings were held and record of the minutes was maintained. The RKS meetings at Hojai FRU were not held this year as the new committee‘s chairman is a State minister and is presumably too busy and preoccupied with more important matters. However, this has not resulted in any delay in decision making and procurement as 99% of the funds were utilised. The Udmari Mini-PHC had not received RKS funds for the

year 2010-11 and had not spent any money for 2011-12. The RKS meetings were regularly held at Udmari Mini-PHC. There were no records of RKS meetings at Kuwaritol PHC. The District Level Vigilance Monitoring Committees need to be notified and established. State should develop monitoring plan for each district with a target to cover at least 20% of the facilities in a quarter. Visit should be prioritizing based on performance.

2.6.2 Chandigarh

RKS have been formed at GH and CHCs (chaired by DC and SDM respectively). Meetings are conducted regularly but documentation can be improved and RKS provides free drugs to patients. VHSCs function erratically. Good VHSC functioning is seen at places like Sarangpur SCs, which had multi stakeholder coordination and used funds to develop infrastructure. Other VHSCs could follow this model. No community monitoring was initiated.

2.6.3 Chhattisgarh

97% Gram Panchayats have formed Village Health Sanitation Committee's, with funds transferred into joint accounts. Funds disbursed earlier have not yet been used, which has limited release for this year. Village Health Sanitation Committee (VHSC) members know of ongoing health programmes but are not informed about their own roles in the system. Panchayat Raj institute involvement could be strengthened especially for participation in Jeevan Deep Society's and VHSCs. Community Monitoring was not being conducted. Jeevan Deep Samiti funds were being well utilized for providing free medicines, surgical aids to patients and improvements are visible. Decentralized action through various community participation strategies like Mitanin programme, Swasth Panchayat initiatives, preparation of Village plans have considerably improved community's participation in the health services.

2.6.4 Kerala

DHAP is available for reference but may possibly be delinked from actual deliverables. There is a need to strengthen the implementation. Micro-level needs have to be factored in to developing plan. Strong PRI involvement at all levels, high visibility in RKS. However, their extent of involvement may vary across districts and have key role in ASHA selection.

RKS/Hospital Management Committee: have representatives of all stakeholders and wield administrative and financial decision-making powers. Funds flow is streamlined and has been used for development of infrastructure, palliative care. Regular meetings are conducted and decisions made by quorum. VHSC members require clarity and orientation about their roles. RKS well functional, with minutes recorded, and there were additional sub-committees for palliative care or the Rapid Response Team. Public Health Infrastructure shows near adequacy – only few SDH gaps remain. Human resource gaps in sanctioned posts are minimal, except for specialists in CHCs. The compulsory Rural Service has ensured regular yearly supply of MBBS doctors in rural areas.

2.6.5 Madhya Pradesh

The DHAP is prepared at district level with consultation with block officials. PRI involvement: Visible in VHSC and RKS functioning and ASHA selection. RKS status has been varies across districts and have user fee charges and these funds are used for facility upkeep. The functioning of RKS has been hampered by delayed funds transfer. Infrastructure Development Wings established at state, division and district level. There was a good progress in constructions. Massive short fall of all Health Sector providers being addressed by contractual staff (specialists, MOs, SNs, others like LHVs), extending retirement age to 65 years, extending recruitment pool to other states, differential remuneration for difficult areas for doctors and nurses have been initiated. PRI involvement in RKS was suboptimal. Perception of RKS is a fund-generation mechanism and not used for improving public participation or quality of care.

2.6.6 Orissa

RKS was functional and effective. Meetings were conducted regularly and minutes was maintained and circulated. Equivalent bodies at GP and district levels also work well. Renovation plans, rate fixing for services was also decided at ZSS meetings. Free drugs provided to patients by RKS funds. VHSCs formed in all GPs. Untied finds have been used for referral transport and sanitation drives. Utilization of Corpus grant to RKS/HMS reported to be good. RKS recruit doctors locally with own funds, and also pay for outsourced support services like sanitation etc. 5,000 functioning GKS. 22 PHCs in 13 districts was being managed by NGOs.

2.6.7 Punjab

DHAP was available but links between physical and financial achievements were mismatched. HMIS and IDSP data should be used for planning. Plans show good understanding of objectives and indicators. RKS Functioning was hampered by erratic funds flow.

2.6.8 Rajasthan

No involvement of PRI members, although role of community representatives increases as one moves to the periphery. State has active role in village health plans. Medical Relief Service MRS (equivalent of RKS) was functional across all facilities. Meetings conducted regularly but agenda largely restricted to monetary issues. VHSCs was formed in most GPs but functionality varies widely.

2.6.9 Uttar Pradesh

In the state village plans were available but queries revealed lack of clarity. DHAP preparation needs to be in participatory process. Plans were not adequately implemented, possibly on account of unrealistic targets.

2.6.10 Uttarakhand

DHAP was non-participatory and RKS has been formed only in selected places. Meetings should follow "due

diligence" norms when they occur, e.g. meeting minutes should be circulated. VHSCs were not fully functional yet and barriers include 1 Pradhan heading 5-6 GPs.

2.6.11 Maharashtra

Although the Plan is said to be top-down, mechanism for participatory monitoring is quite effective. Community monitoring has been practised since 2007. Expansion of CBM was planned this year and structured tools for feedback on services have been used for Jan Sunwais. PRI involvement in VHSC was satisfactory.

RKS was functional across all facilities and composed mainly of PRI and government officials. Funds utilization was nearly 100%. There was a significant contribution to infrastructure improvement with new PHCs and sub-centres, labs, OPDs and wards construction. Infrastructure Development Wing was functioning well.

Initiatives were taken up to improve availability of specialists like seats for PG for MOs in service, withdrawing specialists deputed to Medical Colleges and ensuring hardship allowance for serving rural areas. Efforts to be taken to sustain skills of EMOC trained doctors where C-sections had not started up through elective C-section opportunities. Village Health and Sanitation committees have been set up and functioning satisfactorily in the state. 1056 system for referral transport was present in tribal district (Gadchiroli). Currently community-based monitoring was being implemented in five districts, encompassing 23 blocks and 510 villages.

There was a need for good HR Policy especially for contractual appointments. Training plans for all skill-based training needs to be developed for every district. There is a need to strengthen the state procurement system through formation of an autonomous body and transparent procurement. Enhanced financial allocations for medicines may be considered to improve availability of medicines. Financial Management capacity of facilities to use untied funds was needs to be strengthened

Table 2: Number of RKS and VHSC in India State wise

Sr. No	State /UTs	Rogi Kalyan Samiti (RKS)	Village Health & Sanitation Committee (VHSC)
High focus Non-NE States			
1	Bihar	518	5493
2	Chhattisgarh	932	18570
3	Himachal prades	565	2071
4	Jammu & Kashmir	476	6788
5	Jharkhand	484	30011
6	Madhya Pradesh	1244	24520
7	Orissa	1444	44236
8	Rajasthan	1922	40478
9	Uttar Pradesh	3659	51822
10	Uttarakhand	124	14646
High Focus NE States			
11	Arunachal Pradesh	123	2827
12	Assam	987	26816
13	Manipur	101	3498
14	Meghalaya	133	5568
15	Mizoram	80	813
16	Nagaland	160	1278
17	Sikkim	32	637
18	Tripura	104	1040
Non High Focus States –Large			
19	Andhra Pradesh	1827	21916
20	Goa	14	303
21	Gujarat	1216	17751
22	Haryana	2938	6282
23	Karnataka	3052	23064
24	Kerala	1164	18003
25	Maharashtra	2274	40889
26	Punjab	511	13199
27	Tamil Nadu	1683	15158
28	West Bengal	1362	13312
Non High Focus Small and USs			
29	A & S Island	26	263
30	Chandigarh	3	22
31	D & N Haveli	2	70
32	Daman & Diu	7	28
33	Delhi	0	0
34	Lakshadweep	9	9
35	Puducherry	47	92
	Total	29223	451473

3. Conclusion

The survey was done during the year 2007 to 2011 and named as common review mission (CRM) findings by Ministry of Health and Family Welfare (MHFW), New Delhi. The CRM was mandated to identify the constraints being faced and to make recommendations on the areas that need strengthening. Various states have been incorporated for the survey of Rogi Kalyan Samiti in various primary health care centers in district as well as rural areas. This study shows findings of reviews of RKS in about 22 states such as Assam, Andhra Pradesh, Madhya Pradesh, Uttar Pradesh, Bihar, Chhattisgarh, Gujarat, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Orissa, Rajasthan, West Bengal, Tripura, Tamilnadu, Arunachal Pradesh, Kerala, Uttarakhand, Punjab, Nagaland, Chandigarh and Maharashtra. The present study provides the information based on the survey of Ministry of Health and Family Welfare about constitution, functioning and area of improvement of Rogi Kalyan Samiti in various primary health care centers in above mentioned states.

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