CHAPTER 4
CURRENT SITUTATION OF REPRODUCTIVE HEALTH AND CHILD HEALTH (RCH)

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4.1 POLICIES AND DEVELOPMENT PLANS

4.1.1 Policy on Population and Reproductive Health

(1) International Conference on Population and Development (ICPD) Cairo and National Population Policy

The 1994 Cairo International Conference on Population and Development (ICPD) marked a turning point in the approach that the Government of India (GOI) enunciated for its population and health Programmes. In line with the Programme of Action adapted at the ICPD, Cairo and the Government of India (GOI) espousal of a policy supporting provision of quality services to meet the full range of reproductive health needs of women and couples; it adopted integrated RCH approach and the "target-free reproductive health approach." Method-specific targets were discouraged nation-wide in April 1996.

These are reflected in the Ninth Five-Year National Development Plan (1997-2002) and World Bank supported RCH Programme.

In 2000, National Population Policy were issued, the mid-term and the long-term objectives of which are to bring the TFR to replacement levels (2.1) by 2010, and to achieve a stable population by 2045. In the policy, 14 national socio-demographic goals to be achieved by 2010 are formulated. The major strategies themes are as follows, where needs, decentralisation, convergence, women's empowerment, intra- and inter-sectral coordination & collaboration.

- Decentralised planning and programme implementation
- Convergence of service delivery at village levels
- Empowering women for improved health and nutrition
- Intensified effort on neo-natal care
- Meeting the unmet needs for family welfare services
- Specific measures to under-served · population groups (urban slums, tribal communities, hill area population and displaced and migrant populations, adolescents) and men
- Diverse health care providers and collaboration with NGOs and the private sector
- Mainstreaming Indian System of Medicine and Homeopathy
- Contraceptive technology and research on RCH
- Providing for the older population
- Information, education and communication (IEC)

(2) Madhya Pradesh Population Policy

At the same time of issuing of National Population Policy, State Population Policies are also issued based on the National Population Policy. In Madhya Pradesh, State Population Policy established in 2000. Its mission is **"improving the quality of life of people in the state by *achieving a balance between population, resources and environment.*"** *This mission is to* be accomplished by achieving the main objective: **reaching a TFR of 2.1 by 2011.**

Sub-objectives to be achieved through integrated approach with emphasis on women's empowerment are as follows. Under these four areas, more specific objectives are set about more than 20 items.

(a) increasing contraceptive prevalence through women's and couple's informed and voluntary choice: use of modern contraceptive methods, proportion of couples having an unmet need, proportion of male sterilisation acceptors, use of spacing methods, age at marriage for girls, age of the mother at the birth of her first child, gap between the first and the second child and so on.

(b) reducing infant and child mortality rate: total immunisation, use of oral dehydration salts (ORS) packets, incidence rate of acute respiratory infection (ARI), facilities for treatment of ARI, receipt of all required doses of vitamin A and so on.

(c) reducing maternal morality ratio: registration of pregnant women, proportion of institutional deliveries, assistance of trained birth attendant, pregnancy testing facility, institutions for emergency obstetric care and medical termination of pregnancy and so on.

(d) reducing morbidity of RTIs/STIs:

Key policy initiatives are identified as follows;

- Creating an environment conducive to planned family and creating demand for family planning and reproductive health,
- Increasing collaboration with Panchayati Raj Institutions, the private sector and the non-government sector in community mobilisation and programme implementation,
- Improving the management of the family welfare programme to achieve excellence in meeting the needs of clients,
- Developing appropriate implementing structures.

The concerned departments will finalise an activity plan, implement it, and monitor the progress on a regular basis. To strengthen political support, ensure inter-sectoral co-ordination, and institutionalise integration at district level and below, the following new mechanisms will be put in place:

- The State Population and Development Council (SPDC)
- State Population Policy Implementation Committee (SPPIC)
- District Population and Development Co-ordination Committee (DPDCC)

In December 2001, the GOMP appointed a new commissioner specifically responsible for population and family welfare bedsides the commissioner health. The new commissioner came out with a new initiatives consists of four guidelines and 40 points activities to promote the implementation of State Population Policy.

4.1.2 Other Policies on Health

(1) Draft National Health Policy 2001

Since the last National Health Policy was formulated in 1983, a new health policy has not been formulated in India. However, GOI policies and plans have been described as a development plan for the health sector in each National Five-Year Development Plan.

In 2001 GOI drafted a new National Health Policy (NHP-2001) that has not been finalised yet. It referred to a close relationship between population stabilisation and achieving better national

health standards, and "the principal common features are covered under the National Population Policy 2000 and NHP-2001: the prevention and control of communicable diseases; priority to containment of HIV/AIDS infection; universal immunisation of children against all major preventable diseases; addressing the unmet needs for basic and reproductive health services; and supplementation of infrastructure." It also says that "the synchronised implementation of these two policies will be the very cornerstone of any national structural plan to improve the health standards."

The main objective of the NHP-2001 is to achieve an acceptable standard of good health amongst the general population. The approach recommended is to increase access to a decentralised public health system by establishing and upgrading the infrastructure, and increase public health investment contributed by the central government. It emphasizes a more equitable access to health services across the social and geographical expanse. The NHP-2001 prescribes 23 policies including implementation of public health programmes through local self-governing institutions and increased access of women to basic health care.

(2) Madhya Pradesh Mid-Term Health Strategy

The Government of Madhya Pradesh (the government of MP) does not have any mid- or long-term state vision or plan for the health sector except the budget plans included in the state Five-Year Plan. The budget plans usually follow the National Five-Year Development Plan. Actually most of the major health programmes in the health sector are the National Programmes.

The DOHFW of MP is currently developing a comprehensive mid-term state health strategy and strategies for the next ten years. A team of international and national consultants was contracted to review the health sector and develop the state mid-term health strategy. The draft is expected to be issued in mid-2002.

4.1.3 Development Plan and Health Programmes

(1) *The Ninth Five-Year National Development Plan*

Overall goal of health sector in the Ninth National Five-Year Plan (1997/8-2001/02) is **to improve the health status of the population by optimising coverage and quality of care,** and it emphasizes that the efforts will be directed to improve functional efficiency of the health care system through:

- Creation of a functional reliable HMIS and training, and deployment of health manpower with requisite professional competence.
- Multi-professional education to promote teamwork.
- Skill upgrade of all categories of health personnel, as a part of structured continuing education.
- Improving operational efficiency through health services research.
- Increasing awareness of the community through health education.
- Increasing accountability and responsiveness to health needs of the people by increasing utilization of the Panchayati Raj Institutions in local planning and monitoring.
- Making use of available local and community resources so that operational efficiency and quality of services improve and the services are made more responsive to user's needs.

<Family Welfare>

For the area of family welfare the following specific objectives, strategies, direction of programmes and efforts which should be intensified are set, where also importance of local needs, decentralisation, community participation, intra-/ inter-sectoral coordination and collaboration are stressed.

Objectives

(a) To meet all the felt-needs for contraception

(b) To reduce the infant and maternal morbidity and mortality so that there is a reduction in the desired level of fertility

Strategies

- To assess the needs for reproductive and child health at PHC level and undertake area-specific micro planning
- To provide need-based, demand-driven, high quality, integrated reproductive and child health care.

Direction of the programme

- Bridging the gaps in essential infrastructure and manpower through a flexible approach and improving operational efficiency
- Providing additional assistance to poorly performing districts identified on the basis of the 1991 census
- Ensuring uninterrupted supply of essential drugs, vaccines and contraceptives
- Promoting male participation in the planned parenthood movement and increase the level of vasectomy

Efforts will be intensified to enhance the quality and coverage of family welfare services through;

- Increasing participation of general medical practitioners working in voluntary, private, joint sectors and the active cooperation of parishioners of ISM&H
- Involvement of the Panchayati Raj Institutions for ensuring inter-sectoral coordination and community participation in planning, monitoring and management
- Involvement of tries, organised and unorganised sectors, agriculture workers and labour representatives.

(2) Reproductive and Child Health (RCH) Programme

The Reproductive and Child Health (RCH) Programme was begun in 1997 combining several Programmes that had previously been vertical. In the 1980's and early 1990's India provided primary health care services to women and children under a number of separate, vertical programmes, among them the Universal Immunisation Programme, the MCH Programme, Child Survival and Safe Motherhood, the Oral Rehydration Programme, and others. The target free approach changed its name in 1998 to the Community Needs Assessment Approach (CNAA) to emphasize the positive side of the new orientation.

The Government as well as external donor agencies, including the World Bank and the European Commission, fund the RCH Programme. Thus the RCH Programme is a GOI

Programme that is financed by Indian public funds and donor agencies. It encompasses primary child and reproductive health care provided through the existing health infrastructure, but it does not include other still vertical programmes such as malaria prevention, blindness eradication, Tuberculosis, leprosy, and others whose services are also provided by the same primary health care infrastructure.

The services covered by the RCH programme are:

- The RCH services for women
  - Safe motherhood, including antenatal, natal and postnatal care
  - Nutrition, specifically concerning anaemia
  - Adolescent reproductive health
  - Family planning
  - Abortion
  - Care for RTIs and STIs.

* The Programme also recognises gender issues as important to women's health.

- The RCH services for children
  - Breastfeeding and nutrition
  - Essential new-born care
  - Control of Acute Respiratory Infection
  - Control of Diarrhoeal Diseases
  - Control of Vitamin A deficiency
  - Immunisations

4.1.4 Other Important Reproductive Health Related Policies

The following MP policies also provide a framework and direction for moving towards better health for women and children.

(1) Madhya Pradesh Policy for Women

State Policy on Women issued in 1995 have made serious efforts towards redressing gender inequity. The Empowerment of women to take control of all aspects of women's life is fundamental to sustainable development. The empowerment of women, women's economic, social and cultural development and progress in all sectors are priority areas for the development of MP.

The main goals of the MP Policy for Women are:

- *Ensuring the survival and protection of female life*
- Ensuring the fullest participation of women in Civil Society and strengthening their role in decision making
- Increasing self-confidence and enhancing the status of Women
- Empowerment of women to enable them to take the fullest advantage of developmental efforts in all fields
- Affirmative action to ensure women's full participation in economic activity
- Ensuring the visibility of women in all walks of life
- Bringing about sensitisation and attitudinal change in the larger society on the women's question
- Prevention of atrocities and acts of violence against women.

(2) Nutrition Policy

Programmes and activities against malnutrition, particularly in women and children, are mainly implemented by the Department of Women and Child Development (DWCD) but not by the Department of Health and Family Welfare. The State Nutrition Policy prepared and issued by the DWCD in 2000. , The aim of the policy is to reduce malnutrition, and it emphasizes multi-regional efforts and interdepartmental co-ordination As per the national working plan for nutrition, the state's nutrition policy aims to achieve the following targets by year 2003:

- To reduce the level of moderate malnutrition by 15% and the serious malnutrition by 10% for children under 5 years of age.
- To reduce the cases of low birth weight by 10%.
- To eradicate blindness caused by lack of vitamin A.
- To reduce anaemia, caused by lack of iron, in pregnant women by 20%.

The strategies to achieve the aims are:

- Political resolution and Public Awareness
- Implementation by the Panchayati Raj Institutions and Local Urban Organisations (Decentralisation)
- Special attention on the below poverty line and Tribal families
- Multi-Regional Efforts and Inter Departmental Co-ordination
- Attention to Young Girls
- Monitoring Nutrition
- Establishment of a state Nutrition Cell
- Targeting Families

4.1.5 Other Sub-health Sector Policies

The DPHFW of MP drafted several sub-health sector policies in 2001 with support from DANIDA. Among these, the MP Drug Policy and MP Training Policy (In-service Training) are closely related to improvement of RCH service delivery. However, these policies have not been finalised yet by the government of MP.

<MP Drug Policy (draft)>

MP Drug Policy in 2001 drafted by the DHFW with assistance of DANIDA covers a wide range of areas including availability (selection, procurement, distribution and stock control), financing, quality assurance, rational use, and drug and therapeutic committee.

The followings are the major contents of the draft policy that needs immediate review and finalisation by the GOMP and implementation on the ground.

- Establishment of a State Drugs and Therapeutics Policy Advisory Committee (SDTPAC)
- Review and yearly revision of a Essential Drug List for Madhya Pradesh (EDLMP), use of the EDLMP, and implementation of generic name policy
- Establishment and setting-up of an autonomous corporation (Madhya Pradesh Medical Supplies Corporation: MPMSC) for procurement, distribution and stock management of drugs and medical supplies.
- Introduction of centralized bulk purchase

- Establishment and maintenance of quality assurance and control system under the State Drug Controller including GMP
- A cost-effective and efficient distribution from regional warehouses to district stores by MPMSC
- Delegation of responsibility and financial power from the GOMP to the District Health Committee to make arrangements for distribution of drugs and medical supplies
- Establishment of uniform systems, procedures, records and forms regarding stock management of drugs and medical supplies
- Rational use of drugs and setting of therapeutic committee at each hospital
- Development of a Standard Treatment Guidelines

<Health Sector Training Policy (draft)>

Having recognized the inadequate competence levels and skills of the health care providers is the one of the crucial factors for low performance and effectiveness of health care, the GOMP has drafted the health sector training policy based on the training needs assessment.

The policy emphasizes the strengthening of training systems and institutions. It also emphasizes that training will be integrated with the health system as a sub-system of health system and will be reorganized with strong vertical and horizontal linkages with training institutions and service organizations.

Other policy directions and strategies includes necessity of well-designed integrated in-service training programmes (from multiplicity training programmes and programme specific training to integrated training programme), improvement of training environment (improvement of physical infrastructure, training of trainers and developing competence of trainers), training research and development (developing effective training approach such as problem-solving approach, area-specific approach, distance learning and involvement of NGOs, and evaluation of training and its impact)

The policy objectives are;

(a) Develop and establish an efficient and effective training system, and ensure its effective management

(b) Increase the training capacity of the existing system at all levels, including training the district level

(c) Create an environment that will promote the efforts of developing and testing alternative training approaches in search of the most appropriate and area-specific training strategies

(d) Enhance the training competence of trainers, enabling trainers to acquire high quality training skills and develop confidence in performing the roles of trainers, researcher and consultant most effectively and efficiently

(e) Promote training and health services research, including evaluation of training and its impact

(f) Promote participation of trainers in problems solving and could help health providers in solving problems or testing alternative strategies for service delivery

The following implementation mechanism is recommended;

- Establishment of a Departmental Training Committee at the state level
- Establishment of a training management cell within the human resource development wing of the DHFW, and introduction and maintenance of Personnel Management Information System (PMIS)
- Reorganisation of all health institutions:
    i) all the training institutions will be brought under administrative, financial and technical control of the State Institute of Health Management and Communication (SIHMC)
    ii) the SIHMC gives support and supervision to the Regional Family Welfare Training Centres (RFWTCs)
    iii) the RFWTCs will be responsible for providing administrative, financial and technical support to the District Training Centres (DTCs) and Family Welfare Training Centre in its jurisdiction
    iv) the DTCs will report to the respective RFWTC
- Development of Field Practice Demonstration Area to organize community based training by each HFWTC/DTC

4.1.6 Decentralisation Policy

(1) Decentralised governance through PRIs

GOI encourages decentralised governance through the Panchayat System. Madhya Pradesh was the first state to conduct elections for Panchayat Raji Institutions (PRIs) immediately after the Constitutional Amendment [1]. Since then the government of MP has promoted decentralisation through PRIs in rural areas and ULBs (urban elected local bodies) in urban areas. According to the Panchayat Raji Act of 1993, MP officially transferred authority and responsibility for policy making and programme implementation in 18 sectors including health to the Zilla Panchayat [2].

In January 2001, the government of MP introduced Gram Swaraji system for the purpose of further strengthening decentralisation. This required that Gram Sabha be established in every village and have the responsibility and authority to administer and implement programmes at the village level.

In the health sector, there is little decentralisation to date. Rogi Kaliyan Samiti (patients welfare society), India's cost sharing scheme, is cited by the DPHFW as a successful example of bottom-up planning and decentralised management. Decentralisation in the political structure is emphasised; however, technical support and co-ordination with the health administrative structure and staff at each level (district, block and community level), which is essential for better operation of decentralised governance, has received little attention.

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[1] The large scale of elections for creation of a number of PRIs were conducted based on "Madhya Pradesh Panchayat Raji Act 1993"

[2] 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 & live stock, revenue, social forestry, and labour (Madhya Pradesh Panchayat Raji Act 1993).

Swasth Jeevan Sewa Guarantee Yojana (Rajiv Ghandi Mission for Community Health) was launched in 2001 in MP. This mission programme also emphasises decentralised planning and management in health sector and revitalisation of the village health committee as a core mechanism for community participation in their own health care.

4.2 INSTITUTIONAL FRAMEWORK

4.2.1 Organisation and Administration of Health System

The Department of Public Health and Family Welfare (DPHFW) plays a steering role in the delivery of modern western medicine (allopathic medicine) to the populace of MP. The DPHFW is also responsible for both pre-service training of some groups of health professionals and in-service training of all health professionals in allopathic medicine.

Notable in this structure are two health-related areas not located in the DPHFW: 1) child (to and including age six) growth monitoring, supplementary nutrition, and education on nutrition, tasks which are handled by the Department of Women and Child Development (DWCD); and 2) water and sanitation, which is the responsibility of the Department of Public Health Engineering (DPHE).

Prior to its colonisation by Britain, India had a medical culture that was a combination of two ancient indigenous medical systems, i.e.,. Ayurveda and Siddha whose basic principles were developed in approximately 1000 B.C. Influenced by other imported medical systems, Ayurveda modified its approach and today accounts for a part of the formal alternative health services sector. Homeopathy and Unani, other traditional medicines systems, are also available. These three traditional medical approaches provide health services through their own health facilities and are supervised by the Department of Medical Education and Indian System of Medicine (DMEISM).

(1) Department of Public Health & Family Welfare (DPHFW)

1) State level

a) Secretariat

A Minister, a member of the state cabinet as a politician, heads the DPHFW and is responsible for legislative functions, formulation of government policies, and approval of programmes. Three senior officials (the Principal Secretary assisted by the Secretary, Health and Deputy Secretary, Health) support the Minister and are in charge of health and family welfare services in the secretariat. IAS[1] officials are assigned to these posts.

b) Directorate

Implementation is done through the Directorates of Public Health and Family Welfare Services at the state Level. The Health Commissioner (IAS official) under the Principal Secretary is responsible for overall management of activities and implementation. Presently there are five directors: Director of Public Health and Family Welfare (DoPHFW), Director of Medical Services (DoMS), Director of IEC Bureau (IECB), state Institute of Health Communication and

[1] India has the structured system of governmental personnel that can be roughly classified into Union Government personnel and state Government personnel. Of Union Government personnel, All Indian Services (AIS) are public servants who are assigned either in Union or in state Government. AIS are composed of three types of groups, i.e. Indian Administrative Services (IAS), Indian Police Services (IPS), and Indian Forestry Services (IFS). IAS officials are assigned normally to Director posts in Union Government and to senior official posts such as Secretary in state Government and District Collector.

Management (SIHCM), and Regional Directorates. The Commissioner is also assisted by a Drug Controller (IAS official). (See Figure 4-1)

Policy formation, formation of norms and regulations, budgeting and finance, and supervision of project implementation are carried out at the Directorate level. The DoPHFW is responsible mainly for preventive and promotional health with recent particular emphasis on Reproductive and Child Health (RCH). The DoMS is in charge of monitoring and supervision of curative/clinical services provided by each level of health facilities. Having been a major part of the activities as technical wings of the DPHFW, these two key directors control the Joint Director of Finance. The IECB is responsible for enhancement of public awareness and health education. The SIHCM is the only training institute at the state level, and is supported by four Regional Health and Family Welfare Centres. The post of SIHCM director is vacant and has not been as functioning as it should be. Three Regional Directors[1] oversee health service activities, operate Regional Training Centre (RTCs), and report to the directors of DoPHFW and DoMS.

2) District level

Health administration at district level in Madhya Pradesh is complex. All the departments including the District DPHFW (Department of Public Health and Family Welfare) are under the supervision of the District Collector (DC). The District Chief Medical & Health Officer (CMHO) heads the District DPHFW and is supervised by both the DC and the Health Commissioner. The District DPHFW is staffed by a number of technical officers. Of those, the Additional CMHO, Civil Surgeon, and four District Programme Officers (TB, Leprosy, Blindness, and AIDS) have clinical duties, and they spend their time seeing patients in the district hospital[2]. Few have any management training. Their work is not integrated, resulting in missed opportunities for collaboration and an excessive focus on single programs.[3]

The District Training Officer is responsible for in-service training of health personnel in the district and management of the District Training Centres (DTCs)[4]. Tikamgarh runs the District Nursing Training Centre (NTC). Damoh has none. (Figure 4-2)

a) PRIs and health administration

Each Zilla Parishad (ZP, District local governmental body) has organised a number of standing sector committees. All the ZP standing committees are under the supervision of the Chief Executive Officer (CEO)[5]. A CEO is supervised by both ZP Adhyaksh (head of ZP) and the DC. The CMHO, as an Additional Chief Executive Officer, provides technical support and advice to the health committee that is one of the standing committees of the ZP. Similarly, each Additional CMHO/Civil Surgeon provides technical support and advice to the health committee of the urban local body. *(See Section "4.2.2(2)PRIs and Decentralisation" of this Chapter)*

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1 Madhya Pradesh state is divided into three regions. Each region consists of two or three divisions and each division furthermore consists of five to seven districts. Regional Directors are stationed in the major cities of region and is coordinating between state and regional/divisional levels.

2 The office for the Additional CMHO Civil Surgeon is located in the district hospitals. He or she is charge of health administration for urban areas, clinical practice at the district hospital, district hospital management as a hospital superintendent. District Programme Officers for TB, Leprosy, Blindness, and AIDS are stationed in District DHFW and do also clinical work two or three days per week.

3 Dept. of Health & Family Welfare Government of Madhya Pradesh. Training Needs Assessment, Draft Report 2000.

4 Since the DTC for Tikamgarh district is located not in Tikamgarh but in Jatara, 40km away from Tikamgarh, the District Training Officer is stationed in Jatara.

5 IAS officials are generally assigned to DC and CEO. However, an Indian Forestry Services (IFA) official is exceptionally assigned to CEO for Tikamgarh district.

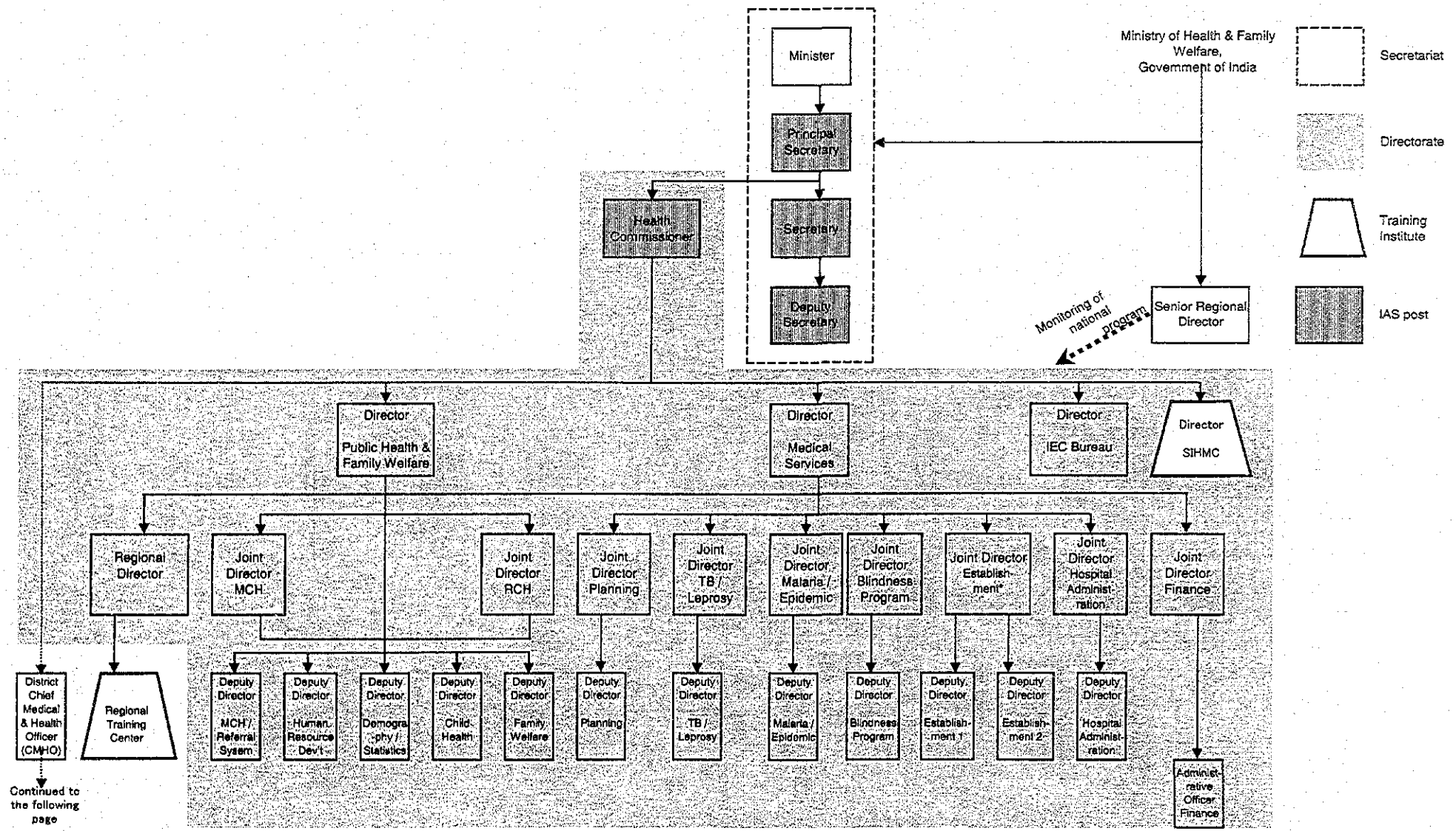
3) Block level

Administratively, each district is divided into several blocks. Although there is no health administration organisation at the block level, Block Medical Officers (BMOs), who head either Community Health Centres (CHCs) or Block-level Primary Health Centres (B-PHCs), are responsible not only for clinical work at those health facilities but for overall health administration within the block. BMOs provide Janpad Panchayat (JP, block level local elected body) health committees with technical support and advice, and they report to the Block-level CEO[1].

The block is divided into health administrative sectors, which cover different geographical areas from those of the administrative areas of other sectors.

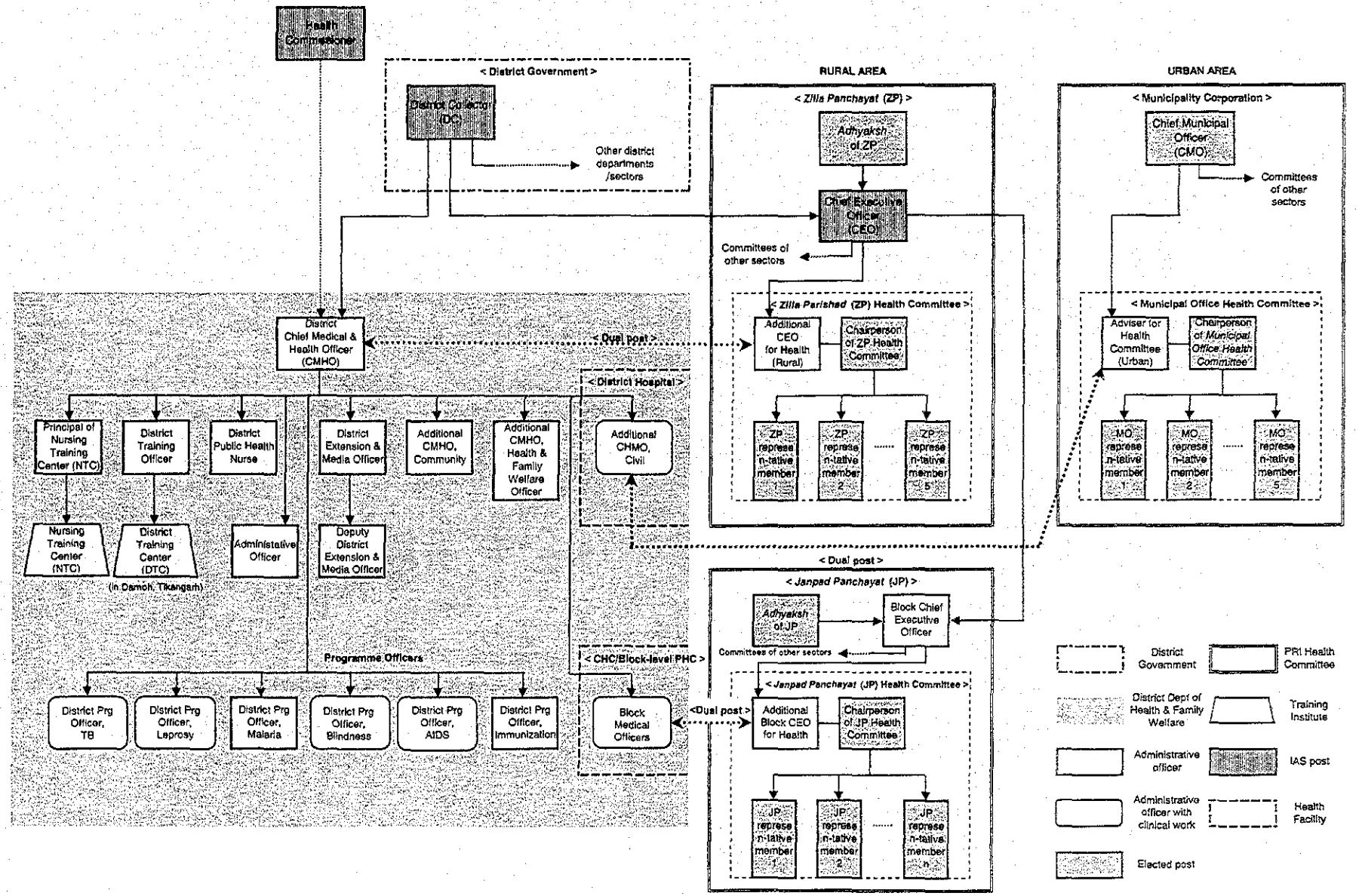
[1] State Government Service Officials of Madhya Pradesh (Class II: middle class) are assigned as Block-level CEOs. State Government Service Officials are classified into four groups, i.e. Class I (high), Class II (middle), Class III (low), and Class IV (support staff).

Figure 4-1 Organizational structure of State Department of Health & Family Welfare in Madhya Pradesh



* "Establishment" stands for personnel affairs such as recruitment and posting of the staff.

Figure 4-2 Organizational structure of District Department of Health & Family Welfare and Panchayat health committees



(2) Other Public Organisation

1) Department of Medical Education & Indian Systems of Medicine (DMEISM)

The Department of Medical Education & Indian Systems of Medicine (DMEISM)[1] is responsible for pre-service training of some health professional groups in allopathic medicine and all the health professional groups in Indian systems of medicine, i.e. Ayurveda, Homeopathy, and Unani that derive from Indian traditional medicines. DMEISM runs five medical and paramedical colleges in the state. DMEISM is also responsible for management and operation of health facilities under the Indian Systems of Medicine.

2) Department of Women & Child Development (DWCD)

The Department of Women & Child Development (DWCD) is responsible for socio-economic empowerment of women and improvement of physical, mental, and intellectual development of children[2]. The DWCD in Madhya Pradesh has five major schemes, i.e., (i) World Bank Cell; (ii) General Integrated Child Development Scheme (ICDS); (iii) Direction Administration; and (iv) other schemes. The ICDS, the principal programme combating malnutrition in pregnant women and children, was launched in 1975 to provide an integrated approach to meet the needs of children under six for health, education, and nutrition. The services provided under the ICDS are:

- Immunisation, health check-up, treatment of minor illness
- Supplementary nutrition (with *Daliya* made from cereals and pulses fortified with vitamins and iron), child growth monitoring, early-childhood care
- Nutritional anaemia prophylaxis
- Education on health and nutrition
- Non-formal pre-school education, and
- Referral services.

The focal point for service delivery under the ICDS is the Anganwadi worker (AWW) and the Anganwadi centre (AWC). The AWW monitors the growth of children in villages where the scheme operates. Beneficiaries are children under 6 and pregnant and lactating women. She also collaborates with the Multi-Purpose Workers (MPWs, male and female) of the Health Department in immunisations. The AWW is a local woman volunteer who receives four months of training and is paid an honorarium that amounts to about US $20/month.

The DWCD also operate other women-related programmes in the state. *(see Sector Report 9 for more details of DWCD and ICDS)*

3) Department of Public Health Engineering (DPHE)

The Department of Public Health Engineering (DPHE) is responsible for designing and constructing (i) rural drinking water supply infrastructure; (ii) urban drinking water supply infrastructure; (iii) rural sanitation facilities; and (iv) urban sewerage systems. Operation and maintenance of the infrastructure is the responsibility of the concerned rural and Urban Local Bodies[3].

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1 In 1995, the Government of Madhya Pradesh divested the responsibilities of medical education and Indian systems of medicine from DPHFW by creating a separate department.
2 DWCD (2000) Administrative Report 1999-2000, DWCD, Bhopal. pp 3
3 http://www.mpgovt.nic.in/phed/

4) Secretariat of the Chief Minister

In 1994 the MP government set about promoting institutional reform and set up seven "missions" to emphasise priority areas for development "with an acute sense of urgency."[1] These are called the "Rajiv Gandhi Missions" and are managed by the Secretariat of the Chief Minister. The missions use often unconventional responses and concerted action to achieve rapid change. The first nine missions addressed were: primary education and literacy, diarrhoeal disease, iodine deficiency, water management, employment, rural non-farm employment, sanitation, municipal solid waste, biomass waste, and industrial waste, and food security of the poorest people in the state.

Each of these missions used existing resources creatively and inter-sectoral approaches. Several are well recognised as successful, such as the missions that addressed iodine deficiency and primary education. ***A new mission for primary health care and family planning was initiated in early 2001*** with a survey (home visit) intended to reach every household in the state. This mission will utilise the design of the Guaranteed Education Scheme in which any community that had 40 potential primary school students (30 in tribal areas) but no primary school could identify a local person who would be trained as a teacher within 90 days by the government.

4.2.2 Political and Administrative Settings and Decentralisation

The state is divided into 12 divisions, and the divisions are divided into districts. There are 45 districts in the new MP, and these are further divided into blocks.

(1) Local Elected Bodies

Madhya Pradesh was the first state to conduct elections of the Panchayat Raji Institutions (PRIs) immediately after the Constitutional Amendment[2]. In 1993 under this legislation, the Government of Madhya Pradesh established elected PRIs at district, block, and small village cluster levels (Figure 4-3).

Local elected bodies in rural areas and urban areas are called Panchayat Raji Institutions (PRIs) and Urban Local Bodies (ULBs) respectively.

1) Panchayat Raji Institutions (PRIs)

In the rural areas of India, the village communities called Panchayats had long existed. After the independence of India, the Government included in the Constitution an Article that defined Panchayats as units of self-government. In 1957 full-scale introduction of Panchayats was launched with recommendations for a three-tiered Panchayat Raji system, i.e.,. Gram Panchayat (village cluster level), Janpad Panchayat[3] (block level), and Zila Parishad (district level).

To tackle the gradual disappearance of the autonomy of Panchayats, election norms were introduced in 1977 to revitalise Panchayats. To further strengthen the PRI function within decentralisation, the 73rd Amendment Act of the Constitution was passed in 1992. Madhya

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1 Research of Economic Policy Implementation & Management. "Madhya Pradesh Partnerships for Development." 2001.

2 The large scale of elections for creation of a number of PRIs were conducted based on "Madhya Pradesh Panchayat Raji Act 1993"

3 Generally the PRI at block level is called Panchayats Samit. In Madhya Pradesh, Janpad Panchayat is used as a common expression exchangeably for Panchayats Samiti.

Pradesh was the first state to conduct election for PRIs immediately after the Constitutional Amendment[1]. In 1993 under this legislation, the Government of Madhya Pradesh established elected PRIs at district, block and village cluster levels. PRIs created in Madhya Pradesh have a three-tier structure (Figure 4-3). PRIs and all the Panchayat related affairs are supervised and monitored by the Department of Panchayat & Rural Development (DPRD).

On the 26th of January 2001, the Government of Madhya Pradesh, introduced Gram Swaraji system for the purpose of further strengthening decentralisation. This required that Gram Sabha should be established in every village and have responsibility for administration of programmes at the village level.

Reservations are made (for women, ST, and castes) for the seats of GP representative members in Damoh and Tikamgarh districts. This is the same for ZP and JP representatives.

Table 4-1 Quota Election System for Gram Panchayat Members (Panch) in MP

Social Class	No. of seats reserved for each social class	No. of seats reserved *for women* *1
Scheduled Castes (SCs)	Proportional to SC / Total population of the village(s)	1 / 3 of reserved seats for SCs
Scheduled Tribes (STs)	Proportional to ST / Total population of the village(s)	1 / 3 of reserved seats for STs
Other Backward Classes (OBCs)	Proportional to OBC / Total population of the village(s)	1 / 3 of reserved seats for OBCs
General class *2	All other seats except the reserved ones for SCs, STs and OBCs	1 / 3 of reserved seats for General class

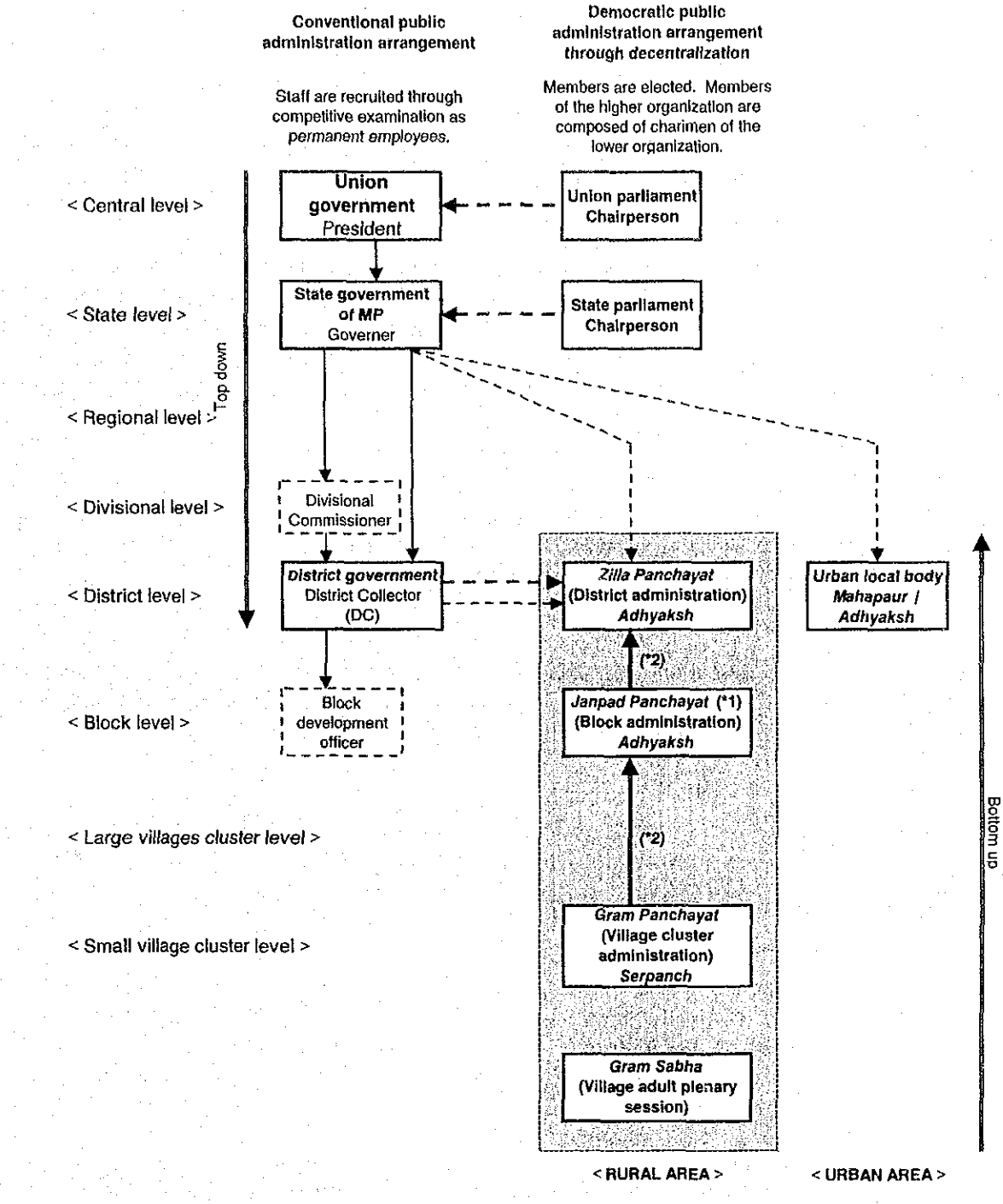
Note: *1) 1/3 of total number of seats is reserved for women in the village(s)
*2) Not only general class men but also other persons such SCs, STs, OBCs and women can run for the offices of general class seats
*3) In Tikamgarh District, no seats are reserved for OBCs because OBCs account for a major part of population.

2) Urban Local Bodies (ULBs)

Similarly to PRIs in rural areas, ULBs are organised in urban areas. There is no tiered system in ULBs. There are three types of ULBs in accordance with the population size of the urban communities: (i) Municipal Corporation with more than 3,000,000 inhabitants; (ii) Nagar Palika with a population between 20,000 and 3,000,000; and (iii) Nagar Panchayat with a population between 5,000 and 20,000. Both Damoh and Tikamgarh cities are categorised as Nagar Palika. Differently from PRIs in rural areas, ULBs are not technically supported by such conventional public administration officials as the CEO. The way in which representative members of the ULBs are elected is similar to the election of PRIs.

[1] The large scale of elections for creation of a number of PRIs were conducted based on "Madhya Pradesh Panchayat Raji Act 1993"

Figure 4-3 General public administration system



(*1) *Janpad Panchayat* " is the expression for "*Panchayat Samiti* " characteristic to Madhya Pradesh.

(*2) Formerly, a "*Sarpanch* " became a representative member of *Janpad Panchayat* . Similarly, an *Adhyaksh* of *Janpad Panchayat* became a *representative member of Zilla Panchayat. Thus,* members distribution was totally arranged in botttom-up approach in the past.

(2) PRIs and Decentralisation

1) Decentralised governance through PRIs

The 73rd Amendment Act on the Constitution passed by Indian Parliament in 1992 encourages decentralised governance through PRIs in rural areas and ULBs in urban areas. According to the Panchayati Raj Act of 1993, the Government of Madhya Pradesh officially transferred authority for policy-making and programme implementation in 18 sectors including health to Zilla Pachayat[1]. The major rationales for the decentralisation are as follows:

a) Enhanced responsiveness to local needs

Many governments, including the Government of India, have tried to devolve health planning, budgeting, and spending authority to districts and lower levels to increase programme timeliness and responsiveness to local needs. People from disadvantaged communities, such as the Scheduled Castes (SCs), Scheduled Tribes (STs), Other Backward Classes (OBCs), and women, are given a forum to speak out, be heard, and to act through the decentralisation process.

b) Efficiency and effectiveness

Particularly in rural areas, active involvement of the local population in development programmes often reduced the cost and increased the effectiveness by enhancing local ownership of the programme[2] and subsequently their sustainability.

c) Transparency and accountability

Reducing the intermediate step that existed between the central and community levels, decentralisation ensures transparency and offers an opportunity for local population to impose transparency and accountability on development administration[3].

2) Health committees of local elected bodies

Both PRIs in rural areas and ULBs in urban areas organise a health committee as one of the standing committees. The missions and functions of health committees under PRIs and ULBs vary slightly as follows:

a) PRIs in rural areas

To carry out the tasks transferred, ZP organises a number of standing committees. The guidelines for standing committees stipulates that: (i) all the representative members are required to be members of one (minimum) to three (maximum) standing committees; (ii) ZP should organise at least seven types of standing committees[4]; (iii) each standing committee is

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1 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 & live stock, revenue, social forestry, and labour (Madhya Pradesh Panchayat Raji Act 1993).

2 E.g., the construction of small bridge in Purulia, West Bengal succeeded in significant reduction in both costs and time through involvement of local population. The official estimates were that it would cost Rs. 210,000 and would take two years to complete the construction. The project was handed over to the local population on condition that it would be constructed without external technical or other assistance. The local population agreed, and not only did they construct it in one year but it cost only Rs. 60,000.

3 E.g., provision of health care in Kerala with involvement of RTIs resulted in better attendance of health officials in district hospitals and in the construction of Primary Health Centres (PHCs).

4 Seven standing committees are composed of: (i) agriculture committee; (ii) education committee; (iii) communication committee; (iv) cooperative and industry committee; (v) health (and women/child) committee; (vi) forestry committee; and (vii) general administration committee.

composed of five or six representative members; and (iv) each standing committee has reserved seats for ST, SC, and women in the same manner as for Panchayat elections.

A ZP Health Committee (ZPHC) is responsible for: procurement of medicaments and supplies, management of paramedical and administrative staff in the district, disease surveillance, epidemic reporting, etc. A health committee is technically supported by the CMHO as an Additional CEO and meets once per month.

Health committees should be organised at each level of PRIs, i.e., JP Health Committee (JPHC) at the block level, Gram Panchayat Health Committee (GPHC) at the community-cluster level, and Village Health Committee (VHC) at the community/village level, a four-tier system. However, communication and interaction between health committees of higher and lower levels seldom occurs. Moreover, functions of the health committees at each level are, in reality, very limited.

b) ULBs in urban areas

For promoting democratisation in urban areas, as in rural areas, the Government of Madhya Pradesh has transferred authority and responsibility for implementation of programmes in various sectors to ULBs. The ULB organises standing committees for each sector.

A health committee, one of these standing committees, has two permanent health technical staff within the committee, i.e., the Health Officer and Health Inspector[1]. Therefore, need for technical support from the Additional CMHO Civil Surgeon is limited and on an ad-hoc basis. In other words, health committees in ULBs may have better technical capacity for implementing projects and programmes compared with the PRIs of rural areas. Activities of the health committees of ULBs include sanitation in the cities and IEC in urban slum areas.

On the other hand, health committees have great potential. Health committees can play a role in: (i) inspection and auditing; (ii) monitoring and supervision; (iii) evaluation; (iv) part of implementation; (v) budgeting and financing; and (vi) needs identification. Table 4-3 and Table 4-4 show roles, responsibilities, and current activities of health committees at each level in Damoh and Tikamgarh respectively.

[1] Health Inspectors have some technical expertise. Health Officers are either recruited from Medical Doctors (MBBS) or promoted from Health Inspectors. The creation of the posts of these health professional staff are based on Municipal Corporation Act 1956 and Municipal Act 1961 (amended in 1992).

Table 4-2 Current Situation of Roles of Health Committees (Damoh)

Possible roles/ responsibilities	ZPHC	JPHC	GPHC	VHC
Inspection & Auditing	The HC used to inspect the district hospital in the past, though not on a regular basis. No such inspection has occurred for the last five months. The hospital authorities were not co-operative. The accounts are discussed in ZP meetings	Committee in its full strength has rarely inspected the CHC. Individual inputs from members are obtained. The accounts are discussed at the JP meetings in presence of the CEO (Block)	(N/A)	The members themselves are not aware of their participation in the committee. The inspection does not take place. No exposure to auditing. (The secretary maintains the income-expenditure records of the VHC)
Monitoring & Supervision	Non-co-operation from health personnel and lack of interest from committee members in monitoring and supervision.	Irregularly performed. Hardly effective.	(N/A)	(N/A)
Evaluation	The committee evaluated the health services for first few months but has ceased to do so since it met last.	Evaluate the services at the meetings, whenever called. Limited to formal discussion.	(N/A)	(N/A)
Part of Implementation	The hospital authorities rarely comply with the suggestion. The Minister In-charge and DC also pay little attention.	Lack of institutionalised efforts to enforce suggestion.	(N/A)	(N/A)
Budgeting & Financing	The ZP prepares the Health Committee budget for health services on its own. The committee members are not interested.	Budgets are discussed at the general session of the JP.	(N/A)	The secretary completes formalities.
Needs Identification	Usually by personal contacts and complaints from the population.	Through movements in the block.	(N/A)	The committee members are not active. The villagers directly approach the MPWs/Anganwadi worker.

Table 4-3 Current Situation of Roles of Health Committees (Tikamgarh)

	ZPHC	JPHC/NPHC	GPHC	VHC
Inspection & Auditing	The committee is not entertained while inspecting the district hospital. The health personnel do not co-operate. The audited records are discussed in the ZP meetings.	The NPHC does not play a role in inspecting the PHC, nor has it been approached. The JPHC members rarely visit the health centre. No exposure to the auditing procedures	(N/A)	VHC does not exist.
Monitoring & Supervision	There is a lack of interest due to limited powers to execute.	The NPHC monitors and supervises the health delivery system through the meetings, though irregular. The BMO and health workers attend the meeting.	(N/A)	Not Applicable
Evaluation	Health services lack adequate will- power to co-operate.	No institutionalised evaluation on part of the NPHC, but the members feel individually that the PHC lacks primary facilities.	(N/A)	The availability of MPWs (M/F) is uncertain at the Centre. (Observation on account of villagers' comments)
Part of Implementation	The ZPHC suggests a lot of measures based on its observations but very few are actually implemented	The NPHC hardly intervenes the functioning of the PHC	(N/A)	(N/A)
Budgeting & Financing	The ZPHC prepares the budget but as the funds are deposited with the Zila Panchayat, which also has the right to approve the budget. It rarely attempts to examine its usage. The Central and state Govt. provide funds besides the funds raised by the ZP of its own resources.	(N/A)	(N/A)	(N/A)
Needs Identification	The members of the committees at lower level –Janpad and village, share their experience and feed back the information. The members hold regional visits to take stock of the situation and aides in the region keep them abreast of the local needs	The NPHC members do not have a defined pattern to identify needs. They do not even meet on a regular basis. Feedback generally comes to them in the form of shortcomings/lack of praise by the population.	(N/A)	The villagers contact the MPW (M/F), Anganwadi worker, and the JSR directly and inform them about their needs. The MPW(M/F) make individual assessment to identify needs (as told by the villagers). An institutionalised system to identify needs is not in place.

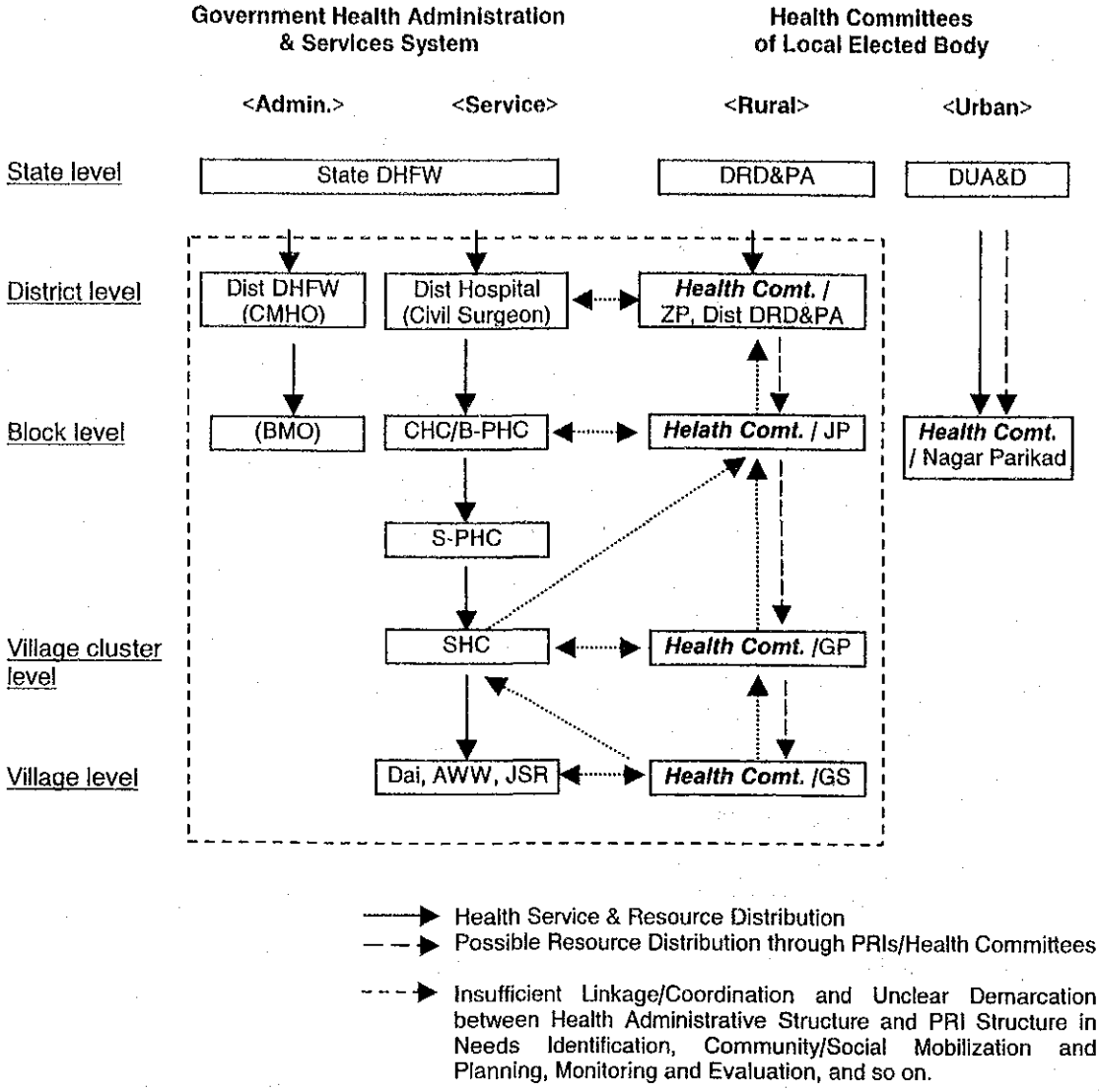

Figure 4-4 Structure of Health Committee

3) Decentralisation in health sector

In the health system, little decentralisation has occurred. The District Planning Committee exists in each district in Sagar Division; however, the health budget has not been transferred to the District level, hiring/firing and assigning of health staff and officers are controlled by the state except transferring staff within the district; and the most health programmes are top-down and vertical. In decentralisation, extensive capacity building of health officers and staffs in planning, monitoring and evaluation, and management in all aspects in health administration is crucial before devolution. Little capacity building has been done.

Under the Rajiv Ghandi Mission for Community Health, the Government of MP and DPHFW recently started development of guidelines for district health planning and preparation of training for district level stakeholders. Decentralisation in planning is expected in the near future.

What authority will be devoted to which level, how, and when is not clear in the process of the decentralisation in health sector.

4.3 RCH SERVICE DELIVERY SYSTEM

4.3.1 Outline of Health Care Delivery System in MP

As already described in the previous section, health services in Madhya Pradesh are delivered by a variety of public and private sector agencies. In terms of health expenditure, the private sector accounts for 80% according to an ADB report. In terms of the number of health facilities, it is said that the private sector accounts for 60% although there is no accurate data. Utilisation of health facilities under the DPHFW is very low except hospitals.

The secretariat of the Chief Minister also has a health scheme, although it does not provide services.

The outline of the health service delivery system in MP is shown on the next page.

(1) Health Service Providers

1) Public health facilities

Several different units deliver health services and health education in the public sector. Health services are mainly provided by the Department of Public Health and Family Welfare (DPHFW) through its health service network of 10,928 facilities. The Department of Women and Child Development (DWCD) also provides health services for women and children, particularly the nutrition programme through Anganwadi Centres in the communities. While these Departments provide western medical services, the Department of Medical Education and Indian System of Medicine (DMEISM) provides services based on traditional medicine: Ayurveda, Homeopathy, and Unani. There are 2,357 facilities under the Department.

There types of health facilities run by the DPHFW are: Community Health Centres (CHCs), Primary Health Centres (PHCs), and Sub-centres (SCs) serving rural areas; Civil Hospitals and Civil Dispensary serving urban areas; and District Hospitals serving the both areas. Teaching hospitals functioning as top referral for those health facilities are owned and operated by the DMEISM. The CHCs are defined as a first referral unit (FRU) at the block level. All former block level PHCs were supposed to be upgraded to CHCs; however, in reality, many are not functioning as FRUs yet.

A number of SCs and some PHCs are without a building constructed by the government. The staff of those SCs or PHCs is advised to rent a building within the designated community. The state DPHFW covers the rental cost of the buildings with a maximum budget of Rs. 1,000 per annum per SC[1]. It should be yet noted that in some villages without a SC building, Gram Panchayat has built a structure for the SC on their own initiative, mobilizing their human and financial resources. Therefore, whether *Gram Panchayat* has built a SC building can be an indicator for measuring the level of willingness to contribute to local health development.

[1] Ministry of Health & Family Welfare. (1999) *Bulletin on Rural Health Statistics in India*, New Delhi, pp. 4

Table 4-5 Outline of Health Care Delivery System in Public Sector

Health Institution		DPHFW (Dept. of Public Health and Family Welfare)		DMEISM (Dept. of Medical Education & Indian System of Medicine)	DWCD (Dept. of Women and Child Development)	Administration
(Service level)	*(Referral)*	*(Health Facility)*	*(Norm of Distribution) ( ): for rural area*	*(Health Facility)*	*(Worker/Facility)*	*(Administrative Level)*
Tertiary	Top Referral	▪ Special Hospital ▪ Teaching Hospital		▪ Teaching Hospital ▪ College Hospital		State
Secondary	Second Referral	▪ District Hospital ▪ Civil Hospital	1/district	▪ Hospital		District
First referral	First Referral	▪ CHC ▪ B-PHC	1/pop. 120,000 (80,000)			District (Block)
Primary with a doctor	First Contact	▪ S-PHC	1/pop.30,000 (20,000)	▪ Dispensary		District (Block/Sector)
Primary without a doctor	First Contact	▪ Rural area: SC ▪ Urban area: UFWC /Civil dispensary	1/pop.5,000 (3,000)	▪ Dispensary		District (Block/Sector)
Community		▪ ANM, F-MPW, M-MPW ▪ Trained Dai ▪ JSR			▪ AWW at AWC 1/pop.1,000	(Village Health Committee)

DPHFW: Department of Public Health and Family Welfare
DMEISM: Department of Medical Education and Indian System of Medicine
DWCD: Department of Woman and Child Development
CHC: Community Health Centre
B-PHC: Block-level Primary Health Centre
S-PHC: Sector level Primary Health Centre
SC: Sub-Centre
FWC: Urban Family Welfare Centre
ANM: Auxiliary Nurse Midwife
F-MPW: Female Multi-purpose Worker
M-MPW: Male Multi-purpose Worker
JSR: Jans Swasthat Rkshak
AWC: Anganwadi Centre
AWW: Anganwadi Worker

Table 4-5 Distribution of Health Facilities in Public Sector in MP

Facility	Number	Population /facility	Facility	Number
Under DPHFW			*Under DOMEISM*	
(Allopathic Medicine)			*(Allopathic Medicine)*	
Specialised Hospital *	3	20,128,373	Teaching Hospital	5
District Hospitals	36	1,677,421	*(Indian Medicine)*	
Civil Hospitals	57		Ayurvedic College Hospital	1
CHC/B-PHC	229	263,690	Ayurvedic Hospital	34
PHC	1,193	50,616	Ayurvedic Dispensary	2,060
SC	8,741	6,908	Homeopathy Hospital	1
Civil Dispensaries (Urban)	115	525,088	Homeopathy Dispensary	201
Post-Partem Centres	39	1,548,336	Unani Dispensary	55
Urban Family Welfare Centres	177	341,159		
Rural Family Welfare Centres	313	192,924		
TB Hospitals and Sanatorium	9	6,709,458		
Leprosy Homes and Hospitals	8	7,548,140		
Mental Hospitals	2	30,192,559		
Poly Clinics	6	10,064,186		
Eye Banks	6			
Blood Banks (licensed)	42			

Source: 1)Annual Administration Report 2000-2001, Public health and Family Welfare Department, the Government of Madhya Pradesh, 2001
2)Health Organisation in Madhya Pradesh, Public health and Family Welfare Department, 1997

Table 4-6 CHCs, PHCs and SCs Sanctioned in MP

	Constructed	Under construction /sanction	Not issued due to limited financial resources	Total sanctioned	*% of facilities without governmental building*
CHC	63	149	17	229	*7.4%*
PHC	536	185+33	439	1,193	*36.8%*
SC	3,079		5,662	8,741	*64.8%*

Source: 1) Annual Administration Report 2000-2001, Public health and Family Welfare Department, the Government of Madhya Pradesh, 2001

2) Health care provider in private sector

The private sector consists largely of NGOs, sectarian groups, private hospitals, and private practitioners of both allopathic (modern) medicine and traditional Indian medicine.

Private providers are the principal source of outpatient curative care in urban and rural areas of India. Private providers tend to be accessible around the clock and are thus considered good sources of emergency care. The quality of care is generally rated better than their government counterparts. Nonetheless, they are perceived as exhibiting limited technical competence.

(2) Norms of Distribution of Health Facilities and Availability of RCH Services

The Union Government defined the norms on distribution of governmental health, and the DPHFW of Madhya Pradesh follows the national norms. As shown in the table below, the

population per health facility is designed to be lower in areas where the poorest, most vulnerable residing.

Table 4-7 Norm for Distribution of DHFW Health Facilities

	District Hosp.	CHC	PHC	SC
General area / plain area	1 per district	120,000	30,000	5,000
Tribal area / hilly area		80,000	20,000	3,000
Ratio with higher health facility	---	(N/A)	4 per CHC	6 per PHC

Source: 1) Directorate of Public Health & Family Welfare, Government of Madhya Pradesh (2001)
2) Bulletin on Rural Health Statistics in India, Ministry of Health & Family Welfare (1999)

The MP Government admitted that due to exceptionally low population density, the norms laid down for the development of the health care delivery infrastructure in the National Health Policy do not ensure availability of and access to basic health services for all sections of the community.

The current situation of health facilities, medical equipment and supplies, human resources, and delivery of RCH services is described in the following section and Sector Report 3.

Table 4-8 Norms for Type of RCH Services provided by Governmental Health Facilities

Type of Reproductive & Child Health (RCH) Services		Teaching Hosp.*	District Hosp.	Rural areas			Urban areas	
				CHC	PHC	SC	Civil Hosp	Civil Disp.
(Norm on number of beds)		(N/A)	(N/A)	(30)	(4 –6)	(0)	(N/A)	(0)
Reproductive Health								
Adolescent health			x	x	x	x	x	x
HIV / AIDS		x	x				x	
Essential Obstetric Care (EOC)	**Antenatal care**	x	x	x	x	x	x	x
	Normal delivery	x	x	x	x	x	x	x
	Postnatal care	x	x	x	x	x	x	x
	Blood test for anaemia	x	x	x			x	
	Blood test for malaria	x	x	x			x	
	Urine test	x	x	x			x	
	Medical Termination of Pregnancy (MTP)	x	x	x	x		x	
	Treatment for septic / spontaneous abortion	x	x	x	x		x	
Emergency Obstetric Care (EmOC)	Caesarean section	x	x	x			x	
	Forceps / ventosa	x	x	x			x	
	Blood transfusion	x	x				x	
RTIs/STIs	Syndromic diagnosis	x	x	x	x		x	
	Laboratory diagnosis	x	x	x			x	
	Treatment for RTIs / STIs	x	x	x			x	
Family planning	*Family planning counselling*	x	x	x	x	x	x	x
	Non-invasive (pill, condom, etc.)	x	x	x	x	x	x	x
	IUD	x	x	x	x		x	
	Norplant	x	x	x	x		x	
	Surgical family planning (Female)	x	x	x	x			
	Surgical family planning (Male)	x	x	x	x			
	Complication of family planning	x	x	x	x			
	Recanalization	x						
Other gynaecological problems	Early detection	x	x	x			x	
	Surgical care	x	x				x	
	Chemotherapy and radiotherapy	x						
Child Health								
New-born care	**Normal new-born care**	x	x	x	x		x	
	High risk new-born care	x	x	x	x		x	
Breast feeding counselling		x	x	x	x	x	x	x
Growth monitoring		x	x	x	x	x	x	x
Immunisation		x	x	x	x	x	x	x
Diarrhea		x	x	x	x	x	x	x
Fever		x	x	x	x		x	
Acute Respiratory Infections (ARIs)		x	x	x			x	
Other PHC								
Tuberculosis		x	x	x	x		x	
Chronic illnesses		x	x	x	x		x	
Others PHC services		x	x	x	x		x	
Health Education								
Nutrition		x	x	x	x		x	
Obstetrics			x	x	x	x	x	x
HIV / AIDS			x	x	x	x	x	x
Child health			x	x	x	x	x	x
Other health services		x	x	x			x	

Note: * Teaching hospitals are attached to medical colleges and operated by DMEISM. All the other types of governmental health facilities in this table are operated by DHFW.

4.3.2 Distribution of Health Facilities in Sagar Division

In the capital of each district there is a hospital that is the main reference centre for the whole district. At the peripheral level, there is a network of health facilities, administratively organised

by block. The distribution of the different levels of health facilities in Sagar Division can be seen in the following tables. These data were obtained directly from the district health authorities. *It should be noted that the number of functioning health facilities is not the same in every document that was given to the team, and information regarding private facilities and practitioners is of poor quality.*

Health structures in Sagar Division number over 1,000. There are approximately 500 people per SC and 47,000 people for each health unit that is supposed to have at least one doctor. However, the number of health facilities in the table below does not show the number with government buildings. In MP 36.8% of PHCs and 64.8% of SCs do not have government facilities. The situation is the same or worse in Sagar Division: 82.8%, 32.7%, 73.5% and 78.2% of SCs in Damoh, Tikamgarh, Sagar and Panna Districts do not operate in government health facilities. This means that most of the SCs are not really health facilities since there is no building to be called such. ANM or MPW works at their homes, at an Anganwadi worker's house, at another village facility, or a rented room. Sometimes they have no place to work.

The problem is not only the number of facilities and buildings, but also their inaccessibility, their poor physical condition, and the lack of human resources capable of solving most reproductive health emergencies.

Table 4-9 Distribution of Health Facilities per District

	Tikamgarh	Damoh	Chhatarpur	Panna	Sagar	MP
Under DHFW						
District Hosp.	1	1	1	1	1	36
Civil Hosp.	0	0	0	0	1	58
CHC	5	1	4	4	9	229
PHC	18	15	41	15	29	1,192
(Population per PHC)	*(66,842)*	*(72,127)*	*(35,967)*	*(56,949)*	*(69,717)*	*(50,616)*
SC	156	162	186	139	245	8,874
*(Rural population per SC)**	*(6,409)*	*(5,470)*	*(6,398)*	*(5,347)*	*(6,090)*	*(5,306)*
Urban FW Centre	1	1	1	1	4	97
Urban Health Post	0	0	0	0	3	80
Civil Dispensary	0	0	1	0	7	97
Postpartum Centre - District level *	1	1	1	1	1	39
- Sub-district level	0	0	2	0	1	57
Under DMEISM Dispensary	28	37	25	14	50	2,352
Under DWCD Anganwadi centre	832	756	880	569	1,308	47,433
Private Facilities	14	8	N/A	N/A	N/A	N/A

Note: * Postpartum Centre at District level is in the District Hospital.
N/A: Data not available

Source: Health Directory-MP, Department of Public Health and Family Welfare, 2001

(2) Damoh District

The entire district has only two health units for referrals: the District Hospital and the Hatta Block CHC. Doctors and nursing staff working in the other 13 PHCs outside of that Block do not have any technical support or a facility to refer patients to other than the District Hospital. Even the Hatta CHC does not provide emergency obstetrical services. There is one urban family welfare centre located in the district hospital. However, it is not functioning well as an urban primary health care centre, particularly for the poor.

Table 4-10 Distribution of Health Facilities by Block in Damoh District

Block Name	Damoh	Patharia	Jabbera	Tendukheda	Hatta	Patera	Batiagarh	Total
Under DPHFW								
Dist. Hosp.	1	-	-	-	-	-	-	1
CHC	-	-	-	-	Hatta	-	-	1
B-PHC	Hindoria	Patharia	Jabbera	Tendukheda		Patera	Batiagarh	6
S-PHC	Abhana	Bansak-ala Shahpur	Roand	Sarra	Madiy-ado Raneh Hinota	Kumhari	-	9
SC	27	23	27	23	22	18	20	162*
Urban FW centre	1	-	-	-	-	-	-	1
Total	31	25	29	25	27	20	16	173
Dispensaries under DMEISM								
Ayurvedic/Unani	7	3	5	6	5	5	4	35
Homeopathic	-	2	-	-	-	-	-	2
Total	7	5	5	6	5	5	4	37

Note: * 28 SCs (17%) are functioning at the government building, 3 at Panchayat building and 131 at rental building., N/A: Data not available

Source: 1) Health Directory-MP, Department of Public Health and Family Welfare, 2001
2) Directly obtained from the District CMHO Offices of Sagar Division
3) Directly obtained from the Department of Medical Education & Indian System of Medicine

(3) Tikamgarh District

In Tikamgarh all blocks have CHCs except Tikamgarh block. In this district the status of the health facilities vary markedly from one to another, although the majority that we visited were in bad conditions and mostly idle. For instance, Bamborikala PHC has a nice new building and adequate staff, but it has no furniture or equipment. On the other hand, the Baldevgarth CHC has an ill maintained building and equipment, yet it is staffed with a medical officer, staff nurses, health supervisors, and ANMs.

Table 4-11 Distribution of Health Facilities by Block in Tikamgarh District

Block Name	Tikamgarh	Baldevgarh	Niwari	Prithvipur	Jatara	Palera	Total
Under DPHFW							
Dostrict Hosp.	1	-	-	-	-	-	1
CHC	-	Baldevgarh	Niwari	Prithvipur	Jatara	Palera	5
B-PHC	Badagaon	-	-	-	-	-	1
S-PHC	Astoan Budhera	Hata Khargapur Baisa Sarkanpur	Orcha Teharka Taricharkala Chandawani	Simra Jiron	Dingora Mohangarh Lidhora	Barana Thar Bamhori Kala	17
SC *	24	27	25	21	34	25	156*
Urban FW centre	1	-	-	-	-	-	1
Total	29	32	30	24	42	28	185
Dispensaries under DMEISM							
Ayurvedic/Unani	3	4	4	4	5	5	25
Homeopathic	1	-	1	-	1	-	3
Total	4	4	5	4	6	5	28

Note: * 104 SCs (67%) are functioning at the government building, 2 at Panchayat building and 49 at rental building, N/A: Data not available

Source: 1) Health Directory-MP, Department of Public Health and Family Welfare, 2001
2) Directly obtained from the District CMHO Offices of Sagar Division
3) Directly obtained from the Department of Medical Education & Indian System of Medicine

(4) Sagar District

In Sagar, all blocks have either a CHC or a B-PHC. However, four out of the 11 blocks have only one PHC each of which supports between 17 and 23 SCs. As in Panna, the vast majority of SCs do not have a building (about 75%).

Table 4-12 Distribution of Health Facilities by Block in Sagar District

Block Name	Sagar	Banda	Rehali	Kesli	Devari
Under DPHFW					
District Hosp.	1	-	-	-	-
Community Hosp	-	-	-	-	-
CHC	Surkhi	Banda	Gadhakota	Kesli	Devari
B-PHC	Shahpur	-	-	-	-
S-PHC	Dhana Karrapur	Chakeri Binaka Patoa	Rahali Chirari Chulla Gujora	Sahajpur Tada	Barkoti Maharajpur Goarjhamar
SC 1 *+ SC 2 **	11 + 19	7 + 17	8 + 18	4 + 17	8 + 14
SC total	30	24	26	21	22
Urban FW centre	N/A	N/A	N/A	N/A	N/A
Total	35	27	31	24	26
Dispensaries under DMEISM					
Ayurvedic/Unani	6	4	7	6	3
Homeopathic	-	-	1	-	-
Total	6	4	8	6	3

Note: * SC 1: with a government building (25% of total SCs)
** SC 2: without a government building,
N/A: Data not available

Block Name	Bina	Malthona	Khurai	Rahatgarh	Jaisinagar	Shahgarh	Total
Under DPHFW							
District Hosp.	-	-	-	-	-	-	1
Community Hosp.	1	-	-	-	-	-	1
CHC	-	Malthona	Khurai	-	Jaisinagar	Shahgarh	9
B-PHC	Aagasod			Rahatgarh			3
S-PHC	Mandi- Bamora	Rajvas Bandri Roda Barodia Kala	Khimlasa	Pipara Sihora Bhaisa Naryawali Jarukheda	Bilhara	Baraidha	26
SC 1 *+ SC 2 **	6 + 14	N/A	4 + 16	7 + 16	5 + 18	2 + 15	62 α +164 α
SC total	20	19	20	23	23	17	245
Urban FW centre	N/A	N/A	N/A	N/A	N/A	N/A	4
Total	23	24	22	29	25	19	289
Dispensaries under DMEISM							
Ayurvedic/Unani	3	4	5	3	3	6	48
Homeopathic	-	-	-	1	-	-	2
Total	3	4	5	4	3	6	50

Note: N/A: Data not available

Source: 1) Health Directory-MP, Department of Public Health and Family Welfare, 2001
2) Directly obtained from the District CMHO Offices of Sagar Division
3) Directly obtained from the Department of Medical Education & Indian System of Medicine

(5) Chhatarpur District

In Chhatarpur all blocks have either a CHC or a B-PHC. It is the district with the most PHCs, although many do not have any doctor. Rajnagar B-PHC is an example of good management and commitment to the provision of high quality care despite its scarce resources.

Table 4-13 Distribution of Health Facilities by Block in Chhatarpur District

Block Name	Chhatarpur	Raajnagar	Nowgaon	Laudi	Gaurihar	Beejawar	Bakswaha	Bada Malhera	Total
Under DPHFW									
District Hosp.	1	-	-	-	-	-	-	-	1
CHC	-	Khajuraho	Nowgaon	-	-	Beejawar	-	Bada Malhera	4
B-PHC	Eshanagar	-	-	Laudi	-	Sataee	-	-	3
S-PHC	Matguwa Barhadi Latera Pourva Ramnagar Koti	Rajnagar Bamiha Jhamtuli Vikrampur Dhawad Karri *Basari* Sillon Chandra-nagar	Maharajpur Harpalpur Garhi Malhara Lugasi Garoli *Alipura* Kuriha	Chandla Chatibam-hori Muderi	Gaurihar Khandeha Barigarh Sarbaee Pehara	Kishangarh Devra Lakhan-guvan Gulganj Angour	Baksawaha	Ramtoriya Bhagwa Dhuwara Sendhwa	38
SC	26	33	26	22	27	19	14	19	186
Urban FW centre	1	-	-	-	-	-	--	-	1
Total	33	43	34	26	32	26	15	24	233
Dispensaries under DMEISM									
Ayurvedic /Unani	2	2	4	5	3	4	2	3	25
Homeopathic	-	-	-	-	-	-	-	-	-
Total	2	2	4	5	3	4	2	3	25

Source: 1) Health Directory-MP, Department of Public Health and Family Welfare, 2001
2) Directly obtained from the District CMHO Offices of Sagar Division
3) Directly obtained from the Department of Medical Education & Indian System of Medicine

(6) Panna district

From a total of 148 health facilities, only 101 may be called as such since about 70% of the SCs have no "facility". Block level PHCs are not yet functioning in every block. Hardua Block has neither a CHC nor a B-PHC to support the activities of the only existing PHC, which has under its responsibility 24 SCs. The Saleha PHC is also responsible for too many SCs (33).

Table 4-14 Distribution of Health Facilities by Block in Panna District

Block Name	Panna	Ajaynagar	Gunnour	Pawai	Shahnagar	Total
Under DPHFW						
District Hosp.	1	-	-	-	-	1
CHC	-	Ajaynagar	Gunnour Amangunj	Pawai	-	4
B-PHC	Devendranagar	-			Shahnagar	2
S-PHC	Brach Kakarhati Hardua- Rakseha Itwakalan	Dharampur Khoura Baryarpur Chandaura	Saleha	Mohendra Simaria	Raipura Harudua- Khamaria	13
SC1*+SC2**	5 + 14	5 + 17	9 + 24	6 + 25	3 + 21	28 + 101
SC total	29	22	33	31	24	129
Urban FW centre	1	-	-	-	-	1
Total	26	27	36	34	27	150
Dispensaries under DMEISM						
Ayurvedic/Unani	3	2	3	3	3	14
Homeopathic	-	-	-	-	-	-
Total	3	2	3	3	3	14

Note: * SC 1: with a government building (22%) ** SC 2: without a government building

Source: 1) Health Directory-MP, Department of Public Health and Family Welfare, 2001
2) Directly obtained from the District CMHO Offices of Sagar Division
3) Directly obtained from the Department of Medical Education & Indian System of Medicine

The current situation of the principal health facilities in Sagar Division is summarised in tables 4-15 ~ 4-19.

Table 4-15 Situation of the Principal Facilities in Damoh District

Facility	Condition
District Hospital	As the only public hospital in the district, it covers a population of 600,000. The hospital began operations in 1954. It has departments of Gyne/Obstetrics, paediatrics, surgery, dental, ophthalmic, X-ray, laboratory, ECG examination, emergency, and pharmacy. With 175 beds including 50 beds for RKS, the hospital provided services to 43,724 outpatients (160/day) and 13,107 inpatients (46/day) last year. It covers all reproductive and child health care. There are 8~9 of normal deliveries and one caesarean section per day on average. The staffs are sufficient in terms of their number indicated in the staffing norm. Medical apparatuses are insufficient. The hospital uses tap water. It has irregular power cuts: the voltage when we visited at 9:50 AM was AC195V with constant fluctuation of ±10 %. (Nominal voltage is240V, and the lower bound within a ±10 % permissible point is 216V, which makes it impossible to disregard the influence on the equipment of the fluctuations in the voltage). It is not a suitable environment for a hospital with the old building, superannuated equipment, insufficient cleanliness, and a lack of consciousness of hygiene among the doctors.
CHC	**Hatta CHC** is located around 37 km away from Damoh District Hospital, covering 185,000 of the district's inhabitants. The CHC has two ambulances and one jeep, and telephone service is available. It has 30 beds. It also has departments of X-ray, Dental, Emergency, and Pharmacy. On average, there is one normal delivery per day at the CHC. Caesarean section is not conducted. EOC and diagnosis and treatment of RTIs/STIs are not provided. They received Drug Kits and Equipment Kits from 1997 to 1999. Contraceptives are provided every month, and vaccines are provided every week. A "Store-in-charge" person maintains registers and manages stocks. They take three films per day with the X-ray 60mA of Siemens, which has been used since 1981. Lack of medical equipment is a serious problem of the CHC.
S-PHC	**Bansakala S-PHC** is 30km away from the Damoh District Hospital in a 2-storied-building (in local facility alone). It has a hand pump well at the front. It does not have X-ray or O.T. equipment, and there are no normal deliveries. Almost all rooms are vacant. We arrived at half past 12 but as it was closed, we called a staff member living near. Electric voltage was AC205V at 12:40. It has a small pond behind the facility.
SC	**Bakayan SC** is located 30km north of Damoh city. It is an Ayurvedic Dispensary of 2 rooms rented from the Gram Panchayat Office. It has operated since 1965. The staff includes 3, Ayurvedic Doctor, MPW and ANM. An average of 12 normal deliveries are conducted per month, and1,646 received diagnosis and treatment number in 2000. The village has electric service but not in the hospital.

Table 4-16 Situation of the Principal Facilities in Tikamgarh District

Facility	Condition
District Hospital	It has operated since 1955, covering the Tikamgarh district of 800,000 of its population. All RCH, Children Services are conducted except blood transfusion. Two X-rays 100MA and 60mA are operated. Others include dental (the unit began in the 1950s), ENT, ophthalmic, laboratory, emergency (one ambulance). The minimal O.T. equipment is superannuated. No anaesthetist; empty blood bank refrigerator. The I.C.U. room has barely a monitor, which is not operating, and a bed. The ophthalmology department has a slit lamp, an ophthalmoscope, and an ophthalmologic operating microscope of Indian make. The 10KVA generator is working.
CHC	**Palera CHC** is 65km northeast from Tikamgarh, or 15km to the Chhatarpur district boundary. Started in 1963, it covers 160,000 inhabitants. Eight beds will be added. EOC, Caesarean delivery,and blood transfusion are not part of the RCH Services. Normal deliveries total 35 per month; other minor surgery, ENT, Ophthalmic, X-ray, Laboratory, Pharmacy. The number of diagnoses in 2000 was 10,000. Neither anaesthetic machine nor monitor for Minor Surgery can be found. All of them super- annuated. Facility management is far from complete; vaccine carriers are thrown in a room.
SC	**Mathoal SC** Unable to get prior information from the CMHO, we found it was ruined after we reached the site.

Table 4-17 Situation of the Principal Facilities in Sagar District

Facility	Condition
District Hospital	The district hospital has a ?? department and an ophthalmic department, whereas the other departments are all scattered throughout the city. It is 100 years since the maternity and paediatric departments were established. A typical old building, with many one-storied wards, it is superannuated. As it was built on a slope, it is difficult to move within the hospital or to access the hospital. We have omitted the details of the hospital as it had been mentioned in the preliminary study report. The level of the underground water is getting lower in the Sagar district, which is causing a serious water problem in the whole district. They draw water from a city pond and deliver water to each place with a tank lorry. However, the water is dirty as buffaloes got in and laundries have used it. The new district hospital, which was separated from obstetrics and gynaecology 28 years ago, consists of the management department, X-ray department (each one Siemens 300mA, 160mA), a laboratory, blood bank, O.T., ICU, Dental, wards and the pharmacy of the Red Cross Society.
CHC	**Deori CHC** is located 65 km west on the main trunk road from Sagar. It covers 153,000 people. Three doctors consult every day, with staffs of 30, including a compounder. 20 normal deliveries per month, 860 minor surgeries, 100~125 X-rays per month and other Lab tests, etc. No dental. The reliable sight of the co-ordinated work of the 3 gentle doctors is now earning the trust of the patients. A good model of CHC. 30 beds available.
SC	**Barcoti SC** is 40kms westward from Sagar city. Opened in 1998, it covers 10,000 people of the town. The building has a S-PHC, but does not have an OT. The staffs are 7 with MO, compounder, LHV, a dresser, a ward boy, a waterman, and a sweeper. They have no more than a sterilizer instrument or a sterilizer can for equipments. No normal deliveries are conducted. The monthly contraceptive distribution consisst of family planning and twice a week, vaccine doses. No power at 15:00 because of irregular power cut.

Table 4-18 Situation of the Principal Facilities in Chhatarpur District

Facility	Condition
District Hospital	A 2-story building faces a shopping street with traffic restrictions. The 2nd floor is mainly for wards, including Red Cross office, burn ward, general ward, and VIP ward. An ophthalmic ward supported by the World Bank was completed in August 2000. There are 148 beds in the surgical, paediatric, maternity, private female, and isolation wards. No one takes care even if floor-cleaning debris from the 2nd floor pours into the courtyard. There were 240V at 11:50, and the electricity was immediately cut. The only ambulance is one of the Red Cross Society. The hospital covers the 1,100,000 people of the Chhatarpur District, numbering 121,290 outpatients and 17,870 inpatients. It has operated since 1940. On the right side of the main entrance there used to be a post office, and now getting rough, worsening the hospital lack of cleanness. It is said that this area is completely out of the hospital management since it is under the control of the post office.
S-PHC	Maharajpur S-PHC is 20km from the heart of the Chhatarpur District. The road to the north is fairly good; however, the condition of the eastward bypath from the trunk line road is very bad. It took 40 minutes by car. The S-PHC has operated since 1950, covering a population of 23,000. The staff includes a doctor, 2 ANMs, one LHV, 5 supervisors, a ward boy, and four others. The S-PHC female doctor is doing her best to improve the conditions of the facility. They enclosed the facility with block walls to shut out animals. They pull water with an electric pump from a well in the front yard into the facility and fumigate constantly. They record medical statistics, the sheets they are using are the backsides of some ads. They do not have any copy machine, so unluckily we could not get a copy of their data. In the delivery room, no apparatus was found except a delivery table. A new part of the building is under construction
SC	Munderi SC is located 60km northeast from Chhatarpur city. It took more than 3 hours because of the terrible road condition. Operated since 1973, it covers 8,000 inhabitants. The staffs are 8 with a doctor, a compounder, NMA, ANM, LHV, MPW, a sweeper and a ward boy. They conduct 6 normal deliveries per month. The patients in 2000 numbered 2,758. The only equipment consisted of the Kits G and I. No electricity.

Table 4-19 Situation of the Principal Facilities in Panna District

Facility	Condition
District Hospital	The hospital, founded in 1962, covers a population of 800,000 with 132 beds. The outpatients were 57,250 and the inpatients 9,424 in 2000. 250 normal deliveries, 26 major and 25 minor operations, and 250 X-rays per month have been conducted. Other departments such as dental, ENT, laboratory, and emergency are functioning. It is comparatively clean because they shut out animals with fences. The X-ray 100mA of GE has been used since 1980. A District Training Centre by UNFPA is under construction in front of the hospital.
B-PHC	**Devendra Nagar B-PHC** is located 20km east of Panna. Constructed 40 years ago, it covers 150,000 people of the region. It has telephones and 6 beds - 2 in the corridor. It has an X-ray of GE but not have a technician who knows how to handle it. The patients numbered 6,000 in 2,000. A patient bitten by a snake was being examined. There are a lot of flies because of the market in front of the facility. Medical wastes such as injections and absorbent cottons were thrown away in the front yard. They have 1 jeep. They were doing some training for Male Health Workers in the facility.
SC	**Banheri SC** is 55 km north of Panna. The access road conditions were terrible. Staffs of 2, MPW and ANM. 25 normal deliveries per month. It has operated since 1970. It covers the Banheri Village of 7,000 people. They pull water with an electric pump into the facility from a well on the site, which is rare for an SC. The voltage showed 145V at 18:05. It was kept, including the toilet, comparatively clean. Water availability may be the big factor.

(7) Condition of Private Nursing Home

The infrastructure of private hospitals (nursing homes) in Damoh, Tikamgarh and Chhatarpur was also surveyed for comparison.

a) Damoh/Nikhi Nursing Home

Located in Damoh, it is one of only a few private hospitals. Located in a house on a shopping street, the nursing home has 6 beds in each male and female general ward, and 3 beds in a private room, numbering 15 beds in total. The bed occupancy rate is 60 %. They see 25 Gyne/Obstertrics cases per day and perform 7~10 surgeries in a month. Blood, urine, and pregnancy tests are conducted in the laboratory. The home consists of nine staff members: 2 permanent doctors, 5 nurses, 1 sweeper, and 1 accountant. The OT has a hydraulic operating table, operation lamps, and a suction apparatus but no aesthetic machine or monitors. The cleanliness is much better than in the public hospitals, but the equipment is insufficient. The home is 10 years old and a new wing is under construction.

b) Tikamgarh/Sewa Nursing Home

Services such as general medicine, gynaecology, surgery (except cancer), ANC (antenatal care), PNC (postnatal care), MTP (Medical Termination of Pregnancy), and LTT (Laparoscopic Tubectomy) are conducted. The home has 18 beds with 14 in a general ward and 4 in a private room. There are 25~30 of outpatients a day. The bed occupancy rate is 50~60 %. Also it has a 24-hour emergency service. They have an X-ray 300mA(GE), Ultrasound scanner (GE), ECG (Philips) as their main equipment. The users' fees are as follows: Consultation Rs.50, Inpatient-general Rs.30, Inpatient-private Rs.100, X-ray Rs.80, Ultrasound Rs.150.

The home has 3 doctors, 4 nurses, 1 lab technician, 1 X-ray technician, 6 ward boys and 1 sweeper. The atmosphere of this home is the same as that of the public facilities, and has rats running through.

c) Chhatarpur/Choubey Nursing Home

It is a private hospital managed by a doctor's family in a business manner, and has a study abroad opportunity in the USA. It has 48 beds in total, including 10 maternity and 16 private beds. The main equipment are an X-ray 200mA, ultrasound scanner, echocardiograph, endoscopes, anaesthesia apparatus, ventilator, pulsoximeter, vital sign monitor, laparoscope, etc., and they are better equipped than in the District Hospitals. The consultation fee is 60Rs, rather expensive (Rs. 2 in Public hospitals); nevertheless, more than 40 patients come to visit per day. Asked whether the fee is uniform, the doctor said they apply a lower fee for the poor people. This is a good example of the doctor's ability and the equipment that attract patients. (There seemed to be some envy because of their profit orientation.)

4.3.3 Human Resources and Human Resource Development in RCH

(1) Staffing Norm

Table below shows the staffing norms for each type of governmental allopathic health facility within a district. In addition to health professionals commonly available in other developing countries, the Indian governmental health scheme has unique health professional groups to strengthen the primary health care, such as Block Extension Educator (BEE), Health Assistant (HA)/Lady Health Visitor (LHV), and Multipurpose Worker (MPW)/Auxiliary Nurse Midwife (ANM). In India there is no midwife as a separate professional group. Instead, some staff nurses specialise in obstetrics, gaining those skills through three-years of in-service training.

Table 4-20 Staffing Norms for Governmental and Community-based Health Professionals

Professional category			District Hosp.	Rural areas				Urban areas		Production	
				CHC		PHC	SC	Civil Hosp.	Civil Disp.	Production scheme *4	Qualification for production scheme *6
Governmental health professionals		Number of beds	100 - 150	30		4 - 6	0	41 - 59	0		
	Medical	Specialist *1	Class I / Class II	Class I / Class II		Class I / Class II	Class I / Class II	Class I / Class II	Class I / Class II		
		Physician	1 1	1	3	- -	- -	1	2	Pm	MD, PGMO
		Surgeon	1 1			- -	- -			Pm	MS, PGMO
		Obstetrician / Gynaecologist	1 2			- -	- -			Pm	MD, PGMO
		Paediatrician	1 2			- -	- -	- -	- -	Pm	MD, PGMO
		Anaesthetist	- 1	- -		- -	- -	- -	-	Pm	MD, PGMO
		Other specialists	1 7	- 1		- -	- -	- -	- -	Pm	MD, PGMO
		General Medical Officer (MO) / Dentist	13	1		1	-	4	-	P	12 Grade
	Para-medical	Head nurse	4 *3	-		-	-	N/A	-	*Pm*	*Staff nurse*
		Staff nurse	24 *3	4 *3		-	-	N/A	-	P Pm + I	12 Grade HA (F) / LHV *5
		HA (Female) / LHV	-	-		1	-	N/A	-	A + I	MPW (F) / ANM
		HA (Male)	1	-		1	-	N/A	-	A + I	MPW (M)
		MPW (Female) / ANM	3	-		1	1	N/A	1	P	10 Grade
		MPW (Male)		-		-	-	N/A	1	P	10 Grade
		Other paramedical staff	21	9		2	-	N/A	2		
	Administrative staff		45	9		2	-	N/A	2	A	10 Grade Diploma
Community-based professionals	Trained Dai		1 per village							P-	Practice
	JSR		1 per village							P-	10 Grade

Note: *1) Both "Class I" and "Class II" are specialised in specific medical area with master or Ph. D. degree. However, as a rule, only "Class I" are called "Specialists" and "Class II" are called "Post Graduate Medical Officer (PGMO)". PGMO are the candidates for "Class I" specialist.

*2) General "Medical Officers (MOs)" are not specialised in specific medical areas with no master or Ph. D. degree. Therefore, there is no possibility for General MOs to be both "Class I" and "Class II" specialists.

*3) "Head nurses" and "Staff nurses" include the nurses specialised in midwifery assigned to obstetric/gynaecological department.

*4) "P" : Produced upon completion of pre-service training programme, "I" : Produced upon completion of in-service training programme, "Pm": Produced upon promotion from lower posts based on the seniority, and "A": Produced based on appointment

*5) "Staff nurses" specialised obstetric skills are produced on in-service training basis (see the section of in-service training in this chapter)

N/A: Data not available

Source: 1) DPHFW (MP), (1998), Staffing Pattern of Health Facilities, Bhopal, pp.1-2

2) Ministry of Health & Family Welfare (1999), Bulletin on Rural Health Statistics in India, New Delhi, pp.3-4

3) www.indiahealth.info.org (World Bank funded Andhra Pradesh Primary Health System Project, 1998-2003)

4) www.aphealth.org (World Bank funded Andhra Pradesh First Referral Project, 1996-2000

(2) Training of Health Service Providers

1) Pre-service training

Major health professionals are produced under the DHFW scheme. DHFW also produces two types of community-based non-governmental health workers: public health guards called Jans Swasthat Rkshaks (JSRs) and trained traditional birth attendants (Dais) through pre-service training[1] for local applicants to the training programmes. Training of physicians, dentists, and nurses is undertaken by the DMEISM, which is a separate department from DPHFW. DLOMEISM also produces Ayurvedic, Homeopathic, and Unani doctors and runs a number of Ayurvedic, Homeopathic, and Unani health facilities.

There are many unqualified doctor called "Registered Medical Practitioners (RMPs)." After serving as an assistant for a qualified physician or senior RMP, he or she gains some skills in curative services. Both the GOI and the government of MP do not approve of RMPs and regard their practice as an illegal one. Previously, the Indian Medical Council registered RMPs, although it no longer does so. Presently the association that registers unqualified doctors is not affiliated with the government.

[1] Since women without any experience as a Dai can apply for the "Dai Training Course", this training programme is classified into pre-service training.

Table 4-21 Health Professionals Produced by Pre-Service Training

Type of health professional	Duration of pre-service training *1	Responsible governmental department	Title of qualification	Sector in which they can work *4	
				Gov't	Private
Allopathic doctor (Specialist)	3 yrs	DMEISM	MS (Master of Surgery), MD (Master of Medicine) *2	x	x
Allopathic doctor (Generalist)	4.5+1yrs	DMEISM	MBBS (Bachelor of Medicine & Bachelor of Surgery)	x	x
Dentist	4+1 yrs	DMEISM	BDS (Bachelor of Dental Surgery)	x	x
Ayurvedic doctor	4+1 yrs	DMEISM	BAMS (Bachelor of Ayurvedic Medical Science) *3	x	x
Homeopathic doctor	4+1 yrs	DMEISM	BHMS (Bachelor of Homeopathic Medical Science)*3	x	x
Unani doctor	4+1 yrs	DMEISM	BUMS (Bachelor of Unani Medical Science) *3	x	x
Nurse	3 yrs	DMEISM	BScN (Bachelor of Science in Nursing)	x	x
Pharmacist (Bachelor)	4 yrs	Gov't: DMEISM Private: DHE	BpharmC (Bachelor of Pharmaceutics & Chemicals)	x	x
Pharmacist (Diploma)	3 yrs	DHE	DPharmC (Diploma in Pharmaceutics & Chemicals)	x	x
Laboratory technician	1 or 2yrs	DHFW	Diploma (2 years), Certificate (1 year)	x	x
X-ray technician	1 or 2yrs	DPHFW	Diploma (2 years), Certificate (1 year)	x	x
MPW (Female) / ANM	1.5 yr	DPHFW		x	
MPW (Male)	1 yr	DPHFW		x	
JSR	6 month	DPHFW	Certificate	*5	x
Dai	1 month	DPHFW	Certificate	*5	x

Note: *1) "+1" stands for one-year internship programme at the teaching hospital in the final academic year.
*2) MBBS is the requirement for entering post-graduate master degree course (specialist course). "MD" is derived from a German expression.
*3) Of one-year internship programme, the initial six-month programme is carried out at Ayurvedic/Homeopathic/Unani hospitals. Then, the second six-month programme can be carried out either at an Ayurvedic/Homeopathic/Unani facility or ordinary western medical facility such as district hospital, CHC, etc.
*4) "G" and "P" stand for respectively "Government sector" and "Private sector".
*5) Since JSRs and trained Dais are not employed and paid by the government, they are classified into private sector. However, they are supervised and technically supported by MPW (Male) and MPW (Female)/ANM stationed at SCs.

The following are descriptions of some health providers listed in the table above.

a) Nurses

Nurses are a higher level of health provider within the system. Thy may have undergone three-years of training in a nursing school after completing secondary studies and have a diploma. Or they may have undergone a 4 year course and have a degree. Usually, both are called staff nurses. Their studies also include midwifery.

b) Auxiliary Nurse Midwife (ANM) / Female Multi Purpose Worker (F-MPW)

The Auxiliary Nurse Midwife, also call the Female Multipurpose Worker (F-MPW) is the female staff member who works in the primary care sites, the Sub-centre (SC) and Primary Health Centre (PHC). With the male MPW (M-MPW) she has the first line responsibility for delivering basic preventive health services.

The major part of her work includes prenatal and postnatal services, health monitoring of pregnant women and under-fives, immunisation, identification of malaria cases and basic treatment, and assisting in organising campaigns and state- or central-level schemes, such as leprosy eradication, TB control, blindness control, etc. She is expected to make home visits on a regular basis, covering four to six villages that may be widely spaced, and a population of 5,000 or more (3,000 theoretically in tribal areas).

In fact, it seems that every new activity places an additional burden on the ANM, who already has numerous responsibilities that go well beyond providing health services and education. For example, every February-March the ANM is expected to visit every household in her catchment area to update the Eligible Couple Register.[1]

c) Dai

The traditional birth attendant of India is called a D*ai*.

The Dai is another important health worker in MP. The Dai is a very important link in the RCH health chain since it is she who has more access to women and children than any other health care provider.

Dais belong to the Basore (an untouchable, or scheduled) caste. Dais learn their skills from senior women in their family, usually a mother or mother-in-law. They provide essential obstetrical care to women during labour and delivery, care for the new-born child, cut the umbilical cord, clean the mother, baby, and delivery room, and bury the placenta. Some Dais, however, begin their work only after the baby has been delivered by someone else, usually a woman relative. They are often called not to conduct the delivery of the newborn, but rather to deliver the membranes only.

The Dai is expected to identify and refer high-risk pregnancies and complicated deliveries; promote the small family norm; and facilitate preventive practices for women and children.

The government of MP policy is to assure that each of the 70,000 inhabited villages in the state has a trained Dai. The government of MP and DANIDA have been supporting or conducting Dai training since the 1980s. To date approximately 30,000 Dais have received training. Training is conducted by ANMs or LHVs in SCs or PHCs. Each Block has a target for training Dais so as to have one trained Dai in each village.

However, there are two problems with this policy. First, the target, which has been a national target since 1977, has not been achieved after almost a quarter of a century, and there are villages without any Dai, trained or untrained. Secondly, some larger villages have both trained and untrained Dais, while the PHCs have ceased training because they have reached their training target, as we found in the Hindoria Block PHC in Damoh district.

The Department of Public Health & Family Welfare (DPHFW) and the Tribal and SC Welfare Department (DTSCW) have an incentive scheme for the Scheduled Caste women who perform deliveries in the rural areas. An incentive in the amount of Rs 40 (25 from the DTSCW and 15 from the DPHFW) is given to each Dai for a delivery. This amount is sanctioned by the collector on the recommendation of the CMHO of each district. The incentive is both an encouragement for Dais to get training since only trained Dais may receive payment, and a welfare programme

[1] Dept. of Family Welfare, Ministry of Health & Family Welfare, GOI. "Guidelines as a Supplement to the CNAA Manual." 1999.

to increase the income of SC women. However, the transfer of funds is very small, representing about 5400 births out of the 2.8 million each year in Madhya Pradesh.

d) Jan Swasthya Rakshak (JSR)

The Community Health Volunteer (CHV) scheme was introduced in 1977 as a way to overcome the deficit of trained doctors, who have an urban orientation that does not seem breakable. In 1981 the term CHV was changed to Village Health Guide (VHG). The VHG was to be selected by the community, provide care for minor ailments, and serve as the link between the community and the public health infrastructure. The community was responsible for oversight of the VHG's work. This scheme never functioned well and was eventually abandoned.

The scheme did not function well because the VHGs were unpaid, working as a social service. At best some were paid Rs. 50 per month and given a small medical kit. In reality, recruitment, training and deployment were left to the PHC, and communities were not trained in their role.

In November 1995 the Madhya Pradesh state government, at the initiative of the Chief Minister Mr. Digvijay Singh, re-initiated this programme as a scheme for developing rural, non-farm employment. The name of the VHG was changed to JSR. The purpose of the JSR scheme is to train educated (ten pass) unemployed rural youth as simple health care practitioners, along the Chinese idea of the barefoot doctor.

The JSRs are supposed to be selected by the Janpad Panchayats, and they are trained at the block level. Following training, the JSR is expected to charge for services. The Block PHC supervises (in theory) the work of the JSR. It is partially a scheme to combat rural unemployment and partially one to expand rural health care. The JSR is also expected to participate with the ANM and AWW in health campaigns or surveys when requested by the government; for this he is often, but not always, paid a small amount. Originally, new JSRs were eligible to receive a loan to start up their practices, but this was discontinued when the financing of the programme passed to the state. The same occurred with the equipment and drug kit that each JSR was to receive upon completing training.

Although it is not clear that the government made any improvements in the failed VHG scheme when it was converted to a JSR scheme, the government of MP is making a major investment in this strategy. One of the state's major goals in the coming years is to train a total of 20,000 JSRs.

Candidates selected for JSR training are almost exclusively male. For example, in Damoh district of 272 trained JSRs only nine are women, and among a group of 15 JSR trainees interviewed in Patera Block of Damoh district in February 2001, all 15 were young males. Among a sample of eight we interviewed, five were between 23 and 28 and three were 30 - 32 years of age; three were unmarried, one widowed, and four married. As a result, their contribution to reproductive health is almost non-existent as many rural women are reluctant to be attended by men - much less young, unmarried men - during delivery. In addition to private practice, JSRs also collaborate with the health authorities announcing family planning or immunisation camps and recruiting and registering participants, useful activities, but not ones that require six months of training.

2) In-service training

In-service training programmes available in Madhya Pradesh are classified into two types according to the purpose: (i) promotional in-service training programmes which upgrade current lower/general posts to higher/specialised posts; and (ii) non-promotional in-service training

programmes which update the health workers' skills necessary for the current professional practices. The most typical promotional in-service training is the HA (Female) / LHV production training targeting MPW (Female) / ANM. The training programme is a six-month course that provide would-be HA (Female) / LHV with supervision skills. Table below summarises non-promotional in-service training programmes that usually take place in District Training Centres (DTCs).

Health workers working in quasi-governmental health facilities (such as military hospitals and police hospitals) do not have an opportunity to participate in in-service training. Most private practitioners are registered in the Indian Medical Association (IMA). However, IMA does not provide member physicians with in-service training programmes.

Table 4-22 Non-Promotional In-Service Training at District Training Centres

Distt.	#	Title of non-promotional in-service training programme	Fiscal Year	Target personnel	Total no. of trained personnel	No. of batches	No. of trainees per batch	Duration (day)
Damoh *1	1	RCH Training Programme 97-98	1997	MPW (Female)/ ANM	162	6	25-30	6
	2	RCH Training Programme 98-99	1998	MPW (Male)	135	5	25-30	6
				MPW (Female)/ ANM	5			
	3	RCH Awareness Training Programme 98-99	1998	GP members School teachers Trained-Dai JSR Anganwadi worker	1,206	40	30-32	2
	4	RCH Awareness Training Programme 99-00	1999		561	20	25-30	2
	5	RCH Integrated Skills Training Programme 00-01	2000	HA (Female) / LHV	28	3	8-10	18
				MPW (Female) / ANM	162	11	14-15	12
Tikamgarh *2	1	RCH Training Programme 97-98	N/A	MPW (Female)/ ANM	N/A	N/A	N/A	6
	2	RCH Training Programme 98-99	N/A	MPW (Male)	N/A	N/A	N/A	6
				MPW (Female)/ ANM	N/A			
	3	RCH Awareness Training Programme 98-99	N/A	GP members School teachers Trained-Dai JSR Anganwadi worker	N/A	N/A	N/A	2
	4	RCH Awareness Training Programme 99-00	N/A		N/A	N/A	N/A	2
	5	RCH Integrated Skills Training Programme 00-01	N/A	HA (Female) / LHV	N/A	N/A	N/A	18
				MPW (Female) / ANM	N/A	N/A	N/A	12

Note: *1) The venues of the training programmes are the District Training Centre in Damoh.
*2) The venues of the training programmes are the District Training Centre in Jatara.
N/A: data not available

3) Training institutes

There are a number of training institutes in Madhya Pradesh. While many of training institutes that provide pre-service training are operated by DMEISM, all of the in-service training institutes are owned and operated by the DPHFW.

Table 4-23 Training Institutes Available in MP

Level	Type of training institute	Type of training programmes			Number of training institutes			Responsible department
		Pre-service training	In-service training		Damoh	Tikamgarh	Madhya Pradesh	
			Promotional	Non-promotional				
State	Medical College	Physician production			0	0	5 *1	DMEISM
	Dental College	Dentist production			0	0	1 *2	DMEISM
	Nursing College	Nurse production			0	0	1 *3	DMEISM
	State Institute of Health Communication & Management (SIHCM)			<TOT> ■ IEC training ■ Administration training ■ Management training ■ TOT: RCH training	0	0	1 *4	DPHFW
	MPW (Female) / ANM Training Center	■ MPW (F) / ANM production			0	0	35 *5	DPHFW
	MPW (Male) Training Centre	■ MPW (M) production			0	0	10 *5, 6	DPHFW
	Public Health Orientation Training Centre		■ HA (F) / LHV production (promotion programme for MPWs (F) / ANM)		0	0	2	DPHFW
	Sister Tutor Training School		■ Staff Nurse Sister Tutor Production (promotion programme for nurses)		0	0	1	DPHFW
Region	Regional Health & Family Welfare Training Centres			■ Specialization of staff nurse in midwifery ■ TOT: RCH training ■ TOT: JSR training ■ TOT: Dai training	0	0	4 *7	DPHFW
District	District Training Centre (DTC)			<Programme training> ■ RCH training ■ TB training ■ Leprosy training ■ AIDS training	1	1 *8	41 *9	DPHFW
	Nursing Training School (NTS)	■ MPW (F) / ANM production			0	1	15	DPHFW
Block	CHC and Block-level PHC *10	■ JSR production ■ Dai production			7	6	343	DPHFW

Note: *1) Five medical colleges are located in Bhopal, Gwalior, Indore, Jabalpur, and Rewa.
*2) One dental college is located in Indore.
*3) One nursing college is located in Indore.
*4) State Institute of Health Communication & Management (SIHCM) is located in Gwalior.
*5) During the period from 1987 to 1997, a number of MPW (Female) / ANM and MPW (Male) were produced through pre-service training at MPW Training Centres built by financial support from DANIDA. However, many of them are either not functioning or transferred to other department such as Department of Industry.
*6) One of 10 MPW (Male) Training Centres is located in Sagar
*7) Four Regional Health & Family Welfare Training Centres (RHFWTC) are located in Gwalior.
*8) The DTC in Tikamgarh district is located in Jatara, 40 km away from Tikamgarh city.
*9) Of 41 DTCs, eight were funded by DANIDA and 33 were funded by the International Population Project.
*10) CHCs and PHCs were not originally training centres but health service providing facilities. However, training programmes for the JSR and Dai are conducted at CHC and PHC